ROBERT WOOD JOHNSON FOUNDATION
HEALTHY NATIONS INITIATIVE EVALUATION

The Stories and Lessons of Fighting Substance Abuse in Native American Communities

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Foreword By Emery A. Johnson, M.D., MPH

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Foreword

Over forty years ago, Dr. Karl Menninger and I were reviewing health problems in a Southwestern American Indian community. One of their major causes of excess morbidity and mortality was substance abuse, primarily alcoholism. Dr. Karl's assessment was that there would be no resolution of this problem until the community developed a "substitute for the drinking society." Experience over the ensuing decades has only reaffirmed that assessment. American Indian and Alaska Native (AI/AN) leaders, their governments, federal health agencies, and the Robert Wood Johnson Foundation (RWJF) have all attempted to create that substitute.

Substance abuse has been recognized as a problem by American Indian tribal leaders since the 19th Century. Concerned tribal leaders repeatedly requested that alcohol not be furnished by trading posts. In 1802, one tribal leader, Chief Little Turtle, in appealing to President Thomas Jefferson, called it a "fatal poison." Over the next 150 years, the Congress passed a number of statutory prohibitions on alcohol sale to American Indians, but none was particularly successful in reducing the burden of substance abuse in AI/AN communities. Finally, in 1953 Congress repealed the federal Indian liquor laws, although tribal governments could still establish restrictions within their own jurisdictions (Indian Health Service Task Force on Alcoholism, 1969).

Substance abuse has been a pervasive problem in many AI/AN communities. In the 1950s, we could say that no Alaska Native family was untouched by tuberculosis; by the 1970s, substance abuse was beginning to

assume that dominance in many AI/AN communities. In a 1985 report, it was noted that alcoholism was "not only the fourth leading cause of mortality in Indians but it is the major contributor to three other of the ten leading causes of death—accidents, homicide, and suicide. In addition, while the documentation is not as complete, alcoholism is a major factor in child and spouse abuse, community and family disorganization, and poor work and educational performance" (Johnson, 1985). While substance-abuse morbidity and mortality rates have decreased, alcohol-specific death rates remain many times higher than those in the general United States community (Howard et al, 2000).

At the time that federal responsibility for providing health care to American Indians and Alaska Natives was transferred from the Bureau of Indian Affairs to the United States Public Health Service in 1955, alcoholism was not found among the ten leading causes of death. In a comprehensive report to the Congress in 1957 by the U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services), alcoholism merited only a single paragraph. Infectious diseases were the focus of concern for the Indian Health Service (then titled the Division of Indian Health) with tuberculosis accounting for almost one-half of the patient days in Indian hospitals (Health Services for American Indians, 1957).

With the marked reduction of infectious diseases over the next decade, the Indian Health Service (IHS) gave increased attention to other causes of excessive morbidity and mortality. Substance abuse, especially alcohol abuse and alcoholism, was beginning to assume the role of the infectious diseases.

Unfortunately, the antibiotics, immunizations, and environmental sanitation that had aided in reducing infectious diseases were not available for the treatment and prevention of substance abuse. New strategies were required.

In 1969, the IHS issued the first of three reports on "Alcoholism: a high priority health problem," presenting information on the general background of the problem in AI/AN communities. The subsequent reports provided guidance on developing activities—balanced between individual treatment for alcohol and substance abuse and for community prevention and treatment activities—and offered recommendations to assist AI/AN communities to take action within their own communities to prevent substance abuse (Indian Health Service Task Force on Alcoholism, Sections One, Two, and Three, 1969-1970). This IHS effort was soon frustrated by the Office of Management and Budget, Executive Office of the President, which felt that IHS should restrict its activities to "medical care" in the traditional Western model; and the problem of substance abuse was assigned to the newly established National Institute on Alcohol Abuse and Alcoholism (NIAAA).

These federal efforts, first by the Office of Economic Opportunity (OEO) that began in the late 1960s and then by NIAAA, focused on programs for the treatment of individuals with alcoholism. While it was recognized that prevention was important, funding restrictions largely limited efforts to involve communities in addressing these problems in a substantive manner. IHS was returned to the AI/AN substance abuse field in 1976 with the passage of the Indian Health Care Improvement Act (P.L. 94-437), which identified substance-abuse treatment and

prevention as a function of IHS. Alcohol treatment programs funded by NIAAA were turned over to IHS beginning in the late 1970s.

While these federal programs were valuable in helping many individuals attain sobriety and in increasing the awareness of AI/AN communities to the ravages of substance abuse, they fell short of generating major changes in the incidence of substance abuse, particularly among youth and young adults. However, nonfederal examples of successful community change were beginning to be reported that emphasized the need for community participation, for their commitment to eliminate substance abuse in their communities, and for change in the behavior not only of individuals but of the community.

The experience of the Alkali Lake Indian Band in Canada was an early model of this successful community action. In my last visit with Chief Andy Chelsea, he described the process of more than a decade of committed change by the leadership and members of the band to create a non-drinking society. The initial activity was taken without outside support; only after the community had demonstrated its determination and ability to create change did the provincial government begin to provide support. He described how a community in which nearly all adult members were alcohol abusers had changed to one in which "only ten or twelve are drinking and they don't drink on the reserve—they go to town to drink." Andy Chelsea's conviction was that "the community is the treatment center."

Although it was clearly recognized that prevention was critical to controlling the problem of substance abuse, unfortunately, the chronic

underfunding of IHS (President's Private Sector Survey on Cost Containment, 1982; Office of Technology Assessment, 1986) allowed only limited IHS expansion beyond individual treatment. By the 1980s, the federal government's emphasis on preventing fraud, waste, and abuse discouraged federal agency innovation and further restricted the opportunity of the federal agencies to support AI/AN community action. It would have been necessary to seek other sources of support for the AI/AN communities if they were to successfully address their substance abuse problems.

The Robert Wood Johnson Foundation was identified as a leading source of support for community health change. Although the Foundation had had little experience in working with AI/AN tribal governments and urban AI/AN organizations, it recognized both the problem and the potential for assisting these groups in improving their health status. The Foundation was, as one grantee stated, also willing to "allow us to use our culture to get things done."

From examination of these earlier efforts came the conviction behind the original 1988-92 Robert Wood Johnson Foundation’s "Improving the Health of Native Americans" program: that change had to come about from within the AI/AN community; that there were leaders in these communities who had the desire and the skills to initiate change, but they needed financial and technical support to be successful; and that, with help, they could make a difference. In this program, tribes and urban American Indian organizations were invited to submit proposals for projects to address their high-priority health problems,

emphasizing activities to prevent illness and injury and to improve the health of infants, children, youth, and the elderly.

A majority of the 36 grants funded were for substance-abuse prevention activities. Grantees, in general, based their strategies on returning to their traditional cultural and spiritual values (Brodeur, 2002). An evaluation following this program identified a number of successful interventions (Berger, 1998).

The RWJF experience with “Improving the Health of Native Americans” led to its decision to support a second grant program focusing on substance-abuse prevention, “Healthy Nations” (HN). This program was modeled after the Foundation's ongoing “Fighting Back” program, which supported community action in developing community knowledge, support, and consensus for action to prevent substance abuse by the members of their community. Healthy Nations, however, had the added factor, prominent in the previous program, of supporting the inclusion of the unique cultural and spiritual elements selected by the grantees, not mandated by RWJF (Brodeur, 2002).

Although the 15 grantees selected in Healthy Nations were a diverse group, ranging from the Eastern Band of Cherokee in North Carolina to the Norton Sound Health Corporation in Alaska, there were many similarities in their strategies. The grantees' prevention worldview began with "culture" including its dynamic for community acceptance. Program mobilization followed a "recreation" (most frequently based on traditional activities) strategy targeting youth and families. Finally, I believe the grantees explored their interactions with a "national initiative" to their benefit and the effectiveness of their efforts.

This report will present the stories of these grantees—their successes, the obstacles they have overcome, the challenges that were met. While there are quantitative comparisons, there is not the detail of a research study. That was considered to be inappropriate due to the concern that the constraints of a controlled study would inhibit the creativity of the grantees in utilizing their cultures and their unique environments in promoting community change.

In looking back over the experiences with the Healthy Nations grantees and considering what we have learned, I thought most impressive were their commonality of experience and commitment to continuing change. The importance of culture, strength of traditional ways (essentiality of personal and community responsibility), response to community desires, promoting of community ownership of change, and identification of institutional change that has been and is continuing to take place were impressive. Healthy Nations was identified not as a "program," but as a "movement." Dr. Karl's "substitute for the drinking society" is being achieved by American Indian and Alaska Native communities.

— Emery A. Johnson, M.D., MPH

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Preface

This manuscript documents the stories of the fourteen Healthy Nations Initiative sites funded by the Robert Wood Johnson Foundation. The structure of the narrative is intended to facilitate reading and relay a sense of time and process. Common factors were attended to in each narrative. The hope is that each site narrative familiarizes the reader with the context, some of the factors interplaying at that moment in time, and the evolutionary trajectory. Although admittedly very naïve and insufficient, there are conscious attempts to infuse cultural colors. It is readily apparent and necessary to disclose that the major author is not a representative of the particular American Indian or Native Alaskan groups. The nature of this inquiry into the historical context and internal mobilization processes of such a rich diversity of cultures leads me to remind those seeking definitive answers and procedural mechanisms that they might not find them within the pages of this report. It is not for the lack of substance or rigorous examination, but because of the structure and nature of the Initiative itself. This is not an excuse for not concluding with authority. Rather, this reflects the diversity of the funded communities, the space within which each community emerged through the background of the many nested expectations, and the dominance of certain perspectives and ways of being.

Multicultural awareness and sensitivity were stretched to their limits during the life of Healthy Nations. The Initiative sites, the National Program Office (NPO), Robert Wood Johnson Foundation (RWJF), and the National Advisory Committee (NAC) all exhibited definitive cultures and traditions. Over the course

of interactions, the balancing of and sorting through of the cultural factors that improved or detracted from the program has proved enlightening, but remains confounded. Interstices and boundary areas in growth and emergence are new targets of scientific investigation. This Initiative was not designed to accommodate the teasing out of these concepts in other than the broadest and, at times, oblique manner. More salient to this manuscript is the articulation of factors such as creative chaos, cultural conflict, amazing effort, and a view within time disclosing the complexity and geometry of change that defined the lives and energy of the Healthy Nations Initiative.

The structure and voice chosen is an attempt at narrative. Since the successes and failures, as well as the mobilization efforts, are stories within the Story, certain guidelines directed the writing of this manuscript. Omitted were names in favor of titles and positions in the organizational charts of the sites. This has two effects: one is positive and limits potential blaming or perceived liability for those whose efforts did not produce desired outcomes; the other is negative because it limits the specific recognition of the many positive efforts and spirit of associated individuals. Our preference, as was that of Dr. Dinges and the RWJF, was to focus on the process—understanding the multi-factorial nature of success and failure—and let the acknowledgements be between those already “in the know.” Each narrative highlights certain programs, activities, and challenges. These, too, are preferences. The data from which to draw the examples are rich and deep. To articulate even a small, representative sample would have pushed the length of this manuscript beyond usefulness and readability. The evaluation

of the mobilization of Healthy Nations in each site appeared best described in the examples and processes included in this manuscript.

Finally, the structure of the manuscript is a compilation rather than a single, integrated document. Three main authors contributed to the mosaic picture of the Healthy Nations Initiative. All of the authors agreed upon this format, which reflects the challenges and fragmented nature of the evaluation concept. As Dr. Taylor most adequately explains: the Healthy Nations Initiative was not designed with robust evaluation in mind. The chapter on the Robert Wood Johnson Foundation and Healthy Nations will shed some light on the history of this complication.

I inherited this project from a friend and new colleague, Norm Dinges, Ph.D., at the University of Alaska Anchorage. Our relationship began as he accompanied grant administrators on site visits to Nome, Alaska, where I was the final director of a Healthy Nations Initiative site. Norm was the evaluator. He presented the evaluation concept as one of outlining the process mechanisms within a historical context wherein the Foundation could recognize the effects of their investment. Such qualitative research generally lends itself to generalities constructed of observed particulars across domains. He was expert at such observations and constructions. For the last two years of the project, he was a friendly but neutral participant with the sites. He visited, talked, interviewed, and witnessed successes and challenges first-hand. He and his staff took notes—many mental, many unreadable—about the data points that he had contracted with the Foundation to “measure.”

In the spring of 2000 on a trip to North Carolina for a site visit, a tragic accident stole all the mental notes, expertise, and history that Norm had observed with the grantee sites. Norm had suffered a significant stoke. The loss suspended the evaluation project and left his staff and colleagues wondering about a hoped-for outcome and conclusion to their effort. There was hope that he would recover and finish the evaluation project. Patience and attendant concern eventually surrendered to the irreparable nature of Norm's condition. Improvements made were woefully short of those hoped for and necessary for resumption of his leadership. Time swept away, and I believe there was some discussion about abandoning this piece of the process.

In December of 2001, the University of Alaska Anchorage, through a circuitous route that still befuddles me, contacted me to review some of the written documentation and create a presentation for a final Healthy Nations Conference in Keystone, Colorado. After encouragement from the Foundation, negotiations with the University, and support from the National Program office, I agreed to this circumscribed task. The negotiations were completed in January of 2002 and the conference was in March. I was wearing two hats then: an ex-director and now this substitute qualitative evaluator. The initial review of the annual reports, existing notes from Norm, and other accumulated documents led to an excitement in the discovery process as well as an important opportunity to see differently the activities among and between the sites, the NPO, and the RWJ Foundation. This four-site sample confirmed some of my suspicions and articulated many of the lessons taught me by my Native Alaskan colleagues and

friends while living in their communities. This initial review also revealed new patterns and processes not readily recognizable from a close association. The methods I used in this first review only partially represented the voice or sweat of the individual communities. Since I personally knew many of the directors and understood some of the challenges they faced, I knew my survey was incomplete. Nevertheless, the information produced was substantive and exciting to the Foundation and those directors in attendance. Those early sentiments of being unable to completely characterize the context, efforts, and outcomes remain today at the end of the evaluation process.

Following that conference, representatives of RWJF, the NPO, and two other colleagues of Norm's—Drs. Tim Taylor and Phil May—met to discuss concluding the evaluation. I agreed to pursue the process with the Foundation through the University. We all agreed that the participatory nature of the original proposal could not be duplicated. It was now the better part of two years since the grant period had expired. We settled on telling the stories instead of evaluating the sites. All present agreed that more happens than is written on structured forms and required reporting and, if available, those were the pieces most interesting. By June of 2002, negotiations were finished and contracts were in place to pursue the more "narrative story" of Healthy Nations. The anticipation of discovering insightful and important patterns and lessons energized the project. One expectation for this evaluation project was to increase understanding of the outcomes and effects of this round of grant making and to inform potential future ventures into Indian Country philanthropy. Such is the

story of my involvement and the attitude of this manuscript. I am attempting to tell the stories of the 14 sites, gleaned from required documents (quarterly and annual reports, program advertisements, and a few pieces of correspondence); incomplete or unreadable notes from Norm and staff (many lost in the confusion; some later found); site-visit observations and impressions; and recorded and transcribed interviews with ex-directors, most of whom have moved on to other activities.

I visited all 14 sites in addition to interviewing all of the Robert Wood Johnson Healthy Nations Initiative personnel, the National Program Officers in Colorado, and some of the National Advisory Committee. Dr. Taylor visited many of these individuals as well gathering his data. I designed and sent a survey instrument to each former director, but after persistent and numerous contacts attempting to elicit responses (there was a substantial stipend attached to returning the survey), only two completed surveys were returned. Historical data and demographics were taken from Phase I proposals. It should be noted that the numbers cited are thus dated and not the reflection of current populations. Finally, I traveled and visited with Norm; I asked for and received permission and blessing from him. His acceptance of my carrying his work forward was very important. All this was completed within ten months of my contract date. The total project—including writing, editing, and life interruptions—has taken 16 months. Such an abbreviated time has taught me to estimate long when negotiating. The original evaluation time period in 1999 was three years. I think we did well.

I must expose my biases. Having been a Healthy Nations grant site director, I have witnessed first-hand the effects of Healthy Nations in Native communities. These experiences, both positive and not so positive, color my affection for the program. I also have some relationship with other Healthy Nations directors. I have experienced many of the things that they shared with me, including frustrations and miscommunications. I also have a strong awareness of the good that the project facilitated in these communities. And finally, the experience in my former role helped me understand the difficulties in representing the processes of another culture. This being said, nothing precluded the effort to try to lend voice to that which I was told by those most intimate with the programs and communities. This resume of experience will most assuredly influence that which I see and present to the reader. Every thoughtful and editing measure is being employed to avoid extremes and one-sidedness. Nevertheless, I assume full accountability for the manuscript. Any errors or misrepresentations are made without malice and should not interfere with the reader's experience in seeking to understanding Healthy Nations.

This manuscript has four distinct parts. Chapters 1-15 are the narratives specific to each site and Robert Wood Johnson. These stories are composed by me, Dr. Randy Moss. First, I included an abridged narrative of the seven years of the Initiative for each grantee site. The format is to contextualize Healthy Nations within each culture, history, geography, and government. The purpose of the narrative is to avoid outlining the processes too directly. This way, the multi-dimensional nature of change—the implicit as well as the formal mechanisms—is

contained but not explicit, allowing the reader to draw parallels outside those officially offered. Lastly, this inclusion of all sites honors each community and gives validity to an effort regardless of the objective evaluation. At the end of each site narrative, I have included a chart of the activities undertaken by that program. This will help the reader understand the scope of the efforts.

Chapter 16 is Dr. Timothy Taylor's quantitative analysis of social indicators for eight sites over matched time periods. These periods are years without the Healthy Nation program and matched timeframes immediately post-program. The presentation is more technical and the comparisons aptly cautioned and inconclusive. Chapter 17 is a side-by-side comparison study of two Healthy Nations sites and two matched non-Healthy Nations sites. Dr. Philip May was the primary author of this section. This analysis of social and health indicators between sites lays the groundwork for future research. The conclusions should not be interpreted as causative. The structure of this section is highly academic but accessible to all readers. The end chapters, Lessons Learned and Recommendations, are the responsibility of Dr. Moss. All authors contributed in the foci of the lessons as well as added important insights.

The writing and presentation of the overall report follow the narrative style. Each section outlines the patterns of mobilization, barriers, and struggles along with successes and triumphs. It is designed not as a "procedural manual," but rather as a treasury of experiences and ideas that worked together to inform, not just the grantee sites but the Foundation. Hopefully, these two sections will

provide some guidance for future investments in American Indian/Alaska Native communities.

Not all of the sites demonstrated the same pattern or structure, although many exhibited a core set of similar processes. What the reader won't find is compelling data, charts, and mechanisms that are failsafe. Such don't exist and, in my opinion, especially not in diverse cultures or in the "boundary areas." The philosophy of "community change" underscoring Healthy Nations needs time and support over this extended time. The Initiative covered an unusually extended period of support (six years with most having a seventh no-cost extension). Nevertheless, the pattern that emerged was that the most powerful and important change happened concurrently to the end of funding. It is my opinion that some change did happen within the assigned timeframe. Those whom I interviewed concurred. The challenge that I hope this manuscript partially reaches is to identify those changes, articulate those in processes and factors that informed the changes, and outline the set of core principles that remain progressively and deliberately shaping these communities. The intent of Healthy Nations was to mobilize the community to address the problems of substance abuse. The data and lessons from Healthy Nations indicate, for some sites, that the Initiative provided a good foundation toward raising the health status and decreasing the pain and disruption of substance abuse in Native communities.

— Randy K. Moss, Ph.D.

Acknowledgements

By Randy K Moss, Ph.D.

I wish to express appreciation to those who have supported this effort. Having dedicated this manuscript to Norm, I thank him for the foundation he established. To his assistants—Jen, who graduated just as I came on board, but who offered insight with her paper, and Deb, who remained until the end, sorting, counting and writing synoptic description of each site—I extend my gratitude. To Phil and Tim, I say thanks. These are experienced researchers and scholars who took and supported my fledgling efforts and added expertise to the editing, analysis, and final product. I number them among my friends. I wish to thank the University of Alaska Anchorage's Institute of Social and Economic Research especially Dr. Scott Goldsmith, Marcia Trudgen, Linda Grant, and Darla Siver. They offered me the job, supported me, and encouraged the process. The RWJ Foundation needs recognition for pushing forward even with lessened expectations and losses in the momentum and having faith in me. Dr. Kate Kraft especially demonstrated concern and help throughout the process. I hope that you are satisfied with the results of your faith and patience. A special thanks to all those with whom I visited—ex-HNI directors and program officers, whose lives have changed as each moved on, have undertaken new projects, and who retrieved much of the information I needed from long-stored files and memories; I requested a day of interruption, reminiscences, and reconstruction from each of them, some of which was not always bright and shiny. Thank you for inviting me into your communities and sharing the honesty and insights. You are all beautiful.

To my staff, especially Debi Shade, your flexibility and understanding cannot be fully described. I owe you big time. Finally, to my family—Nancy, Elliot, Taylor, Cambria, and Madison—I must acknowledge your sacrifice. The days away, the early morning trips to the airport, the shoveling of the snow while I was gone, the meals with Dad gone or just “spaced out” are your immeasurable contributions to this project. I love you and could not succeed without all your support and encouragement.

I hope that this effort supports those individuals, families and communities, especially our Native communities who are struggling to maintain and reclaim wellness hope and power from the tyranny of substance abuse.

Acknowledgements

By Timothy Taylor, Ph.D.

Special thanks and appreciation go to the current and former Healthy Nations directors who gave of their time and their expertise. I am especially indebted to Kim Azure, Jim Quaid, and Jim McQuillen.

A very special thanks and appreciation to Bernie Ellis, who provided information he collected and prepared for McKinley County and Gallup, New Mexico.

To Dr. Randy Moss, who came to the HNIE during a difficult time and has done a wonderful job—many thanks!

Finally, to Dr. Phil May, a highly respected colleague and good friend; thank you, thank you!

Acknowledgements

By Philip A. May, Ph.D.

I am grateful to have had the chance to be a part of the Healthy Nations program at various points along the journey. I am grateful to Robert Wood Johnson Foundation for taking this chance on indigenous models of prevention, especially Annie Lee Shuster and Dr. Ruby Hearn. I am also grateful to Spero Manson, Ph.D., and Candice Fleming, Ph.D., for the fostering and facilitating role that they played from the start. It was not an easy role that fell to the National Program Office. It was a pleasure to serve on the National Advisory Committee and to interact with the various tribal communities and the HNI staff of each. I am especially grateful that Norm Dinges talked me into being a part of this evaluation and to Tim Taylor for all his hard work with this project and with me. Finally, Randy Moss, Ph.D., picked up the pieces from what could have been an aborted evaluation project; put his time, energy, heart, and soul into it; and created a final product that will serve as a fitting history of HNI and a road map for the future.

Executive Summary

By Randy K. Moss, Ph.D.

The Healthy Nations Initiative: Reducing Substance Abuse among Native Americans (HNI) was underwritten by the Robert Wood Johnson Foundation. From 1992 through 2001, fourteen American Indian/Alaska Native sites were supported by $13.5 million in developing programs that addressed four outlined grant components: public awareness, community-wide prevention, early identification and treatment, and accessible aftercare and relapse prevention. The Foundation assembled a committee of Native-issue experts following the internal negotiation, preparation and approval of letting of funds. HNI was informed, in part, by two previous Foundation grants: Improving the Health of Native Americans and Fighting Back. The concepts and structure of HNI were innovative and courageous for the Foundation.

The fourteen sites represented a purposeful geographical, cultural, and rural/urban mixture; they were the following: Central Council of Tlingit and Haida in Juneau, Alaska; Cherokee Nation of Oklahoma in Tahlequah, Oklahoma; Cheyenne River Sioux of Eagle Butte, South Dakota; Confederated Salish and Kootenai of St. Ignatius, Montana; Confederated Tribes of Colville Reservation of Nespleum, Oregon; Confederated Tribes of Warm Springs Reservation of Warm Springs, Oregon; Eastern Band of Cherokee of Cherokee, North Carolina; Friendship House of Oakland/San Francisco, California; Northwest New Mexico Fighting Back of Gallup, New Mexico; Norton Sound Health Corporation of Nome, Alaska; Seattle Indian Health Board of Seattle, Washington; Twin Cities of

Minneapolis/St. Paul, Minnesota; United Indian Health Services of Eureka, California; and White Mountain Apache of White River, Arizona. Selected from approximately 85 original proposals and from a cohort of 25 sites that received pre-award visits, these grantees participated in both phases of the Initiative. Initially there were fifteen groups funded, with two being eliminated for difficulties in maintaining cohesion in the catchment population requirements. Later in the transition to Phase II, a Foundation-funded Fighting Back site was added to complete the fourteen.

The HNI was a two-phase program with each site receiving a flat $150,000 for a feasibility and planning stage of up to two years. The sites were then eligible for a non-competitive, second-phase funding cycle of up to one million dollars over four years. Administration was layered, with the Foundation maintaining direct involvement and participation while assigning the development and operations to a National Program Office (NPO) consisting of experienced Native academic leaders. The NPO had two co-directors, consistently, and three deputy directors, successively, during the course of the Initiative. Further support for the program was provided by a National Advisory Committee (NAC) assembled of seasoned researchers, teachers, and leaders in Indian issues. A combination of Foundation, NPO, and NAC members constituted the traveling teams that made site visits, facilitated semi-annual grantee meetings, and structured accountability to the individual site goals and general grant requirements. Each site was required to successfully survey their communities, identify prevention venues and activities, set goals and program targets, and

develop a plan in the first two years. Across sites, the completion of Phase I components proved difficult, posing challenges to transition to Phase II or the "implementation stage." Factors contributing to the transition problems were staffing changes, tribal leadership shifts, failure to address all grant components, conflicts between clinical services and HNI, documentation confusion, and perceived lack of understanding of the vision and freedom inherent in the grant structure.

Eventually, with patience and numerous interventions from the NPO, all sites transitioned into Phase II. The first two years of this stage remained a development and learning process for both the Foundation and grantees. Reporting issues consumed much energy and supervision. Ongoing changes in program managers and tribal organizational placement eroded program growth, created an ahistorical programming line, and necessitated re-teaching of the protocol, vision, and expectation of the grant. Meanwhile, NPO changes and philosophy shift prepared the Initiative to experience a successful growth during the last three years (most sites had a no-cost extension).

Formal evaluation of the Initiative was originally contemplated but judged as a possible deterrent to innovation. It was noted that many tribes were tired of being "researched"; therefore, inclusion of a rigorous evaluation would have limited the application pool. Nevertheless, all sites were informed that some rough quantitative measures would be collected and analyzed. Further, a qualitative review focusing on formative and mobilization processes was to be undertaken. This was announced as being informative to the Foundations, the

sites, and future grantors. Formal work on this type of evaluation began in mid-Phase II. This process was interrupted by personal tragedy and reassumed 18 months later as a narrative view of the formation of HNI principles in each unique grantee context. The quantitative piece compared social indicators of eight sites pre- and post-Initiative using regional and state data. This data was inconclusive in regard to HNI attributable changes.

Another quantitative piece looked at indicators of substance abuse and effects across four matched sites, two being HNI grantees. The re-analysis of these data demonstrated a modest improvement in knowledge, drinking severity, and consequence in favor of the HNI sites. Again, caution is raised in over-interpreting the data. The formative narrative is a compilation of process, struggles, and successes of each site in the mobilization of prevention programming in their communities. The narrative evaluation articulates patterns that arose across contexts, the mobilization processes, and the lessons learned for both the Foundation and the grantees. Highlights of these are presented herein. For more thorough coverage and details see RWJF Healthy Nations Initiative Evaluation: The Stories and Lessons of Fighting Substance Abuse in Native American Communities by Randy K. Moss, Ph.D.; Timothy Taylor, Ph.D.; and Phil A. May, Ph.D (2003).

HNI confirmed that stable and informed leadership and staffing produced more mature programs. While commonsense, the frequency of staff turnover in Indian communities clarified the need for more directed, conscientious, and programmed support, development, and retention of staff. This must be done

without imposing outside vision and interrupting the natural selection process demonstrated across many HNI sites. HNI clearly showed the vulnerability of creative and self-determined programs to be co-opted into existing service sectors or redirected to non-targeted projects. HNI showed that good staff are absorbed into other tribal positions, experience burn-out in protecting the integrity of the developing program, or become radically politicized. While this is a natural course in many organizations, grass-root philosophies like HNI without prescribed activities or outcomes demand vigilance to leadership development. Those sites with less turnover demonstrated more robust community involvement, more institutionalization of philosophy and behavior, and better post-funding program component survival.

HNI leadership placement in the tribal organizational chart was essential. More than two steps away from central government of the organization exposed the program to hostile take-over attempts, wide swings in program direction, and risk of separation and eventual alienation from core services. Focusing on greater and broader understanding and alliance within the tribal leadership concerning the grant as well as placement of the program strategically in the organization will facilitate growth, offer mobility, and be more responsive to the community through better coordination, consistency, and advocacy.

HNI privileged “culture” differently than the near hyperbole surrounding cultural sensitivity. HNI sought to move the lived “culture” of the community from the silent and private universal background to a position of vibrant foreground. Through administrative, financial, and extended time involvement, the natural

culture bearers, the hidden community shapers, and the local connectors were supported and trusted. Over the extended seven-year period of HNI accessibility, the communities voiced, developed, and participated in truly culturally relevant, health-promoting, and healing activities. The reclamation of pride in tradition, the sharing of wisdom, and tribal life was demonstrated in HNI programs that decreased violence between rival gangs through genealogy, reconnected grandfathers with lost grandsons of the tribe, and transformed weekend parties into ceremonial tribal gatherings. HNI did not engage “culture” as a tool or strategy of intervention but rather privileged the local context and spirit to be the healing medicine and nurturing ground of prevention and change.

One key element was flexible funding. Allowing the HNI staff to invest in local ideas and to support community-generated activities, which lacked explicit connection to some external logic model or best practices, was a hard and well-earned success. Breaking the paralysis imposed by the long-standing fraud and abuse posture of governmental funding, the tribes and, to some extent, the Foundation became liberated to be truly responsive to community voices. This reality was most prevalent in the last three years of HNI. The convergence of trust with resources infused power into community-generated healing in these Native communities. This outcome of HNI represents the most powerful and effective components that evolved during the mobilization process. Community-based programming was finally legitimately privileged over academically researched models. The results were multitudes of participants and local organizers exposed to positive messages and elevated in social influence by HNI

philosophy and trust. These people, young and old, represent the seeds of change and health identified and planted with few dollars and much respect. Flexible funding was central to the overall success of the Initiative. The addition of Fighting Back New Mexico after five years previous funding and then for an additional four years demonstrated that length of steady funding creates mature programs. Most programs were just bearing fruit when the funding discontinued. The realities of Native programming are that sustainability is linked to the next grant. Long, flexible investment is the lesson for future success in promoting community-based programming in Native communities.

HNI began with a solid idea that evolved from just another grant into a health movement across all sites. Today, remnant components of Healthy Nations carry the name and philosophy proudly in different programs by different people. The strength and success of a program is judged by the institutionalization of the vision, philosophy, and energy. HNI has been a success of different degrees bringing results in the slow, anticipated logic dealing with long-term and chronic problems such as substance abuse. Initiatives like Healthy Nations provide resources to facilitate communities and their citizens to recapture hope and pride and to forge a bright future.

ROBERT WOOD JOHNSON FOUNDATION
HEALTHY NATIONS INITIATIVE EVALUATION

1992 - 2002

“From Eastern Halls and Board Meetings to Stick Games and Talking Circles”

Robert Wood Johnson Foundation/Healthy Nations Narrative

Historical Context:

The Robert Wood Johnson Foundation (RWJF) is the largest health- and health-care-related philanthropy in the United States targeting health and health-related issues. Founded in 1972 by the heir of Johnson and Johnson products, the Foundation has been actively funding research in four basic areas—access to quality health care; improved care for chronic health conditions; healthy communities and lifestyles; and reduction in personal, social, and economic harm due to substance abuse, tobacco, alcohol, and illicit drugs. Consonant with these goals, the Healthy Nations Initiative (HNI) was conceived and ultimately funded in 1992. The Initiative was not the Foundation’s first foray into Indian country and the health issues rampant in these communities. But unlike the usual strongly academic or large institution-granting activities, Healthy Nations and its predecessor, “Improving the Health of Native Americans,” represented a departure from the long-established protocol.

The culture of the Robert Wood Johnson Foundation might be inferred from its structure, history, and focus. A strong corporate organization administered by a highly educated and expert board of trustees with a predominantly medical and research-trained infrastructure, the Foundation is nationally respected for its visionary leadership, health care initiatives, and business professionalism. Generally administered by a physician with a staff of Ph.D.s, MPHs, and research fellows, the Foundation is seen as a force and

leader in the research community. To receive a grant award from the Robert Wood Johnson Foundation carries significant weight and prestige. The long history of important research projects completed, the influence exercised in public and private sectors, the list of esteemed grant recipients, and the strength and exactness of their program designs set them apart as a benchmark of science and success.

The vast number of important health issues requiring research and attention always out-stretch the resources of even the most affluent philanthropy. The Foundation, for all its structure and protocol, responds to issues that gain the interest of a senior staff person and can be promoted in both hallway conversations and formal board rooms. Such was the case of the Healthy Nations Initiative. The Foundation's experiment in Indian Country with "Improving the Health of Native Americans," directed by Dr. Timothy Taylor, proved both successful and informative. Its character was that of investing in tribal organizations by supporting their choices of health issues to be addressed. This grant required layered and multiple solicitations from the sites over a three-year period of funding. Many of the sites identified substance abuse as their choice. This was not a surprise, nor was it unanticipated. So during the late 1980s, the Foundation funded selected programs in some Native communities throughout the United States. In the early 1980s, Mrs. Annie Lee Shuster attended a meeting in Arizona on the Navajo reservation, where she connected with Emery Johnson, M.D., past IHS director. The story goes that during a car ride from the conference on Indian health, the beginning ideas for Improving the Health of

Native Americans germinated. Concurrently, substance-abuse prevention and treatment enhancements were hot topics. The federal government had stepped away from “innovative research,” and the treatment community was looking for better practices. Likewise, the prevention movement that started in the early 1980s was maturing, with emphasis going toward community-wide and community-led strategies. The decision makers and researchers at the Foundation were reportedly aware and engaged in furthering these efforts. The confluence of these factors created a rich and nourishing environment for advocating a program like Healthy Nations.

The birth of Healthy Nations followed roughly three years of incubation at the Foundation. The decisions to target substance abuse in American Indian/Alaska Native communities came after many discussions among Foundation staff, including Annie Lee Shuster and Dr. Ruby Hearn, a senior vice-president with RWJF. Discussion with Emery and other Foundation consultants, including Spero Manson, Ph.D., of the Colorado Health Services Center; Dale Walker, M.D., of the University of Washington; and Philip May, Ph.D., of the University of New Mexico outlined the basic structure of what would be called Healthy Nations. Those associated investigated existing research that informed and helped construct the philosophy and components of the grant. Following the well-established mechanisms of launching a call for proposals, the Foundation assembled a small cadre of seasoned experts in Native issues as an advisory committee. Annie Lee and Ruby outlined the concepts and components and presented them in PowerPoint form at program staff meetings. After a series of

formal discussions and hallway advocacy contacts, the idea was taken to the Executive Board of RJWF. The same procedure was implemented and in the end, funding for Healthy Nations was authorized. A financial note was attached along with the project budget developed by the Foundation staff. This was early 1991. The Foundation had conceived and labored with the concepts, finally celebrating the emergence of this unique grant opportunity. But the process was far from complete.

The Foundation uses national program offices to husband projects and oversee grants. They consistently choose the finest and most qualified individuals to act in this capacity. Consistent with the philosophy of excellence, the Foundation contracted with a known Native American researcher to act as the National Program Office (NPO). Trusting the engineering and architecture of a granting opportunity to such an individual is standard procedure at RWJF. Spero Manson, Ph.D., an American Indian of Chippewa heritage, was the selected candidate for the Program Officer. As director of the National Center for American Indian and Alaska Native Mental Health at the University of Colorado Health Science Center, Spero had numerous projects on his dossier. He arranged for co-directorship with a colleague at the Health Science Center, Candace Fleming, Ph.D., of Oneida, Kikapoo, and Cherokee descent. This tandem was charged with developing a call for proposal. They, together with a series of three program deputy directors, administered the grant from development to final evaluation.

Generally, the Foundation formally contacts known experts and researchers in the field under investigation and invites them to be a national advisory committee member. Under signature of the Foundation president, they send letters of invitation. The Healthy Nations Initiative was no different. A group of experienced scholars, researchers, and policy makers engaged in Native issues were assembled. The National Advisory Committee (NAC) was formed and joined in the responsibility of site selection and informing the NPO.

The call for proposals was completed in early 1992. The advertising of the grant opportunity was published as a well-crafted brochure in registries and bulletins that typically announce calls for proposals. Further, the NPO and NAC made extensive efforts to inform Native American groups and tribes. Since the target population was Native American, such efforts were necessary to assure greatest participation. The NPO held three information and orientation conferences in Minneapolis, Seattle, and Denver. Here, the details of the call for proposal were shared with attendees from around the country. Technical support and clarification of instructions were given. Many potential sites representing a broad spectrum of Native tribes, institutions, and organizations attended. About 85 Native groups submitted Phase I proposals, which were carefully reviewed by the NAC, NPO, and the Foundation. Using criteria of catchment population size, basic infrastructure, proposal clarity, sophistication, expertise, and demonstrated need, these original applicants were ranked and screened down to a group of 25 by the NAC members. Any further winnowing necessitated a more thorough review and site visit. A combination of NAC members, NPO personnel, and

(mostly) Annie Lee Shuster from the Foundation visited each site. The final number of awardees was determined partly on the viable applicant pool and available funding. Resources were available to fund fifteen sites. Using a predetermined cross-section of geographical locations and types of organization (urban, reservation, and remote), the NAC and NPO recommended the fifteen sites.

Phase I of the ***Healthy Nations Initiative: Reducing Substance Abuse Among Native Americans*** was finally underway. This process continued into 1993. Phase I was a two-year development/feasibility stage. Each site was awarded $150,000 per year to survey their community, develop plans and solutions, and test some of the ideas to prepare the grantee to submit Phase II, four-year implementation proposals. All grantees were expected to address four components seen by the Foundation and NPO as essential to the intent of Healthy Nations. The four components were (1) a public awareness campaign designed to generate broad-based tribal and community support for effort to reduce demand for tobacco, alcohol, and illegal drugs; (2) a multifaceted, community-wide prevention effort targeted especially at children and adolescents that could include (a) prevention programs in the schools and in community settings; (b) development of recreational and cultural activities promoting self-esteem; and (c) prevention training for teachers, health care workers, and others; (3) special programs to promote early identification and treatment for substance abuse among youth and other high-risk tribal members, such as pregnant women; and (4) a range of accessible options for substance abuse treatment and

relapse prevention as well as outreach to families of people with substance abuse problems.

The grant obligations, especially from the point of view of the grantees, were demanding. Each was required to document the related needs in their catchment area; collaborate with other agencies, including governments and outside organizations; and develop a detailed work plan, including strategies to be used during the period of the Foundation's funding and also to continue these efforts into the future. Within months of the award notices, two sites began an unremitting slide into insupportable conflict and disorganization. These two sites had been joined together in order to meet the catchment population requirements. Some of the groups had irreconcilable historical animosity that undid the coalition. Geographical and communication complications posed further challenges. Although concerted and focused efforts were made by the NPO and the NAC to support these tribal groups in solving their challenges and conflicts, these sites were dropped from the funded sites by the end of Phase I. The rest of the sites struggled under the demands but maintained their funding viability.

Phase I was a period of learning and organization for all involved parties. Grantees held meetings to offer support and to provide an opportunity for them to share. The NPO conducted numerous site visits, attempting to assist each site in meeting the Phase II criteria. Although Phase II was not the usual competitive process, each site needed to demonstrate viability and sufficient planning and execution of their work plan to get to the next round of funding. The NPO was the

administrative and technical support center. With an NAC member and (many times) Annie Lee Shuster or other Foundation staff, the NPO would visit the grantee site to ensure compliance to the regulations crafted by the NPO outlined in the call for proposals in order to meet Foundation requirements. Some of the site visit were celebrations of successes and were received in happiness and gratitude. Many of these site visits were not pleasant and were locally perceived as heavy handed. At the transition into Phase II, thirteen sites remained, but many were marginally prepared or mature to make the move. The transition period bridged months and included numerous iterations of Phase II proposals from some sites. The NPO and NAC conducted more and regular site visits, provided technical support, and even mentored final preparations of proposals. Since these were nominally competitive at this juncture, the intent was to support success as often and as much as possible. In some instances, even these efforts failed to garner the expected results, and some site visits included less-than-veiled indications that further funding was not forthcoming. Thirteen original sites remained. Concurrently, the RWJ Foundation had previously been involved with another community-based substance abuse prevention initiative entitled “Fighting Back.” One rural, primarily American Indian Fighting Back site in New Mexico was ending its program simultaneously with the transition of Healthy Nations into Phase II. NAC members familiar with the work of this particular program introduced the idea of extending this particular program by substituting it for one of the two programs unable to finish Phase I. In the end, the New Mexico

Fighting Back site was added and, therefore, fourteen sites constituted the Healthy Nations family.

The NPO was also involved in interacting with the culture and structure of the RWJ Foundation. Although mostly behind the scenes from the grantees, negotiations and advocacy for the sites took place. Annie Lee Shuster remained active in the direct oversight of the program. Others at the Foundation had begun transitioning out of direct involvement. The NAC even experienced an internal shift with some original members who resigned over differences in philosophy and program management. The NAC members participated in the semi-annual grantee meetings and also accompanied the NPO to site visits. Their role, however, remained somewhat hidden from, and undefined to, the grantees. The NPO deputy directors were the lead contacts for most sites. By mid-Phase II, the structure of the Healthy Nations administration was well-understood by the grantees. Changes in the communities and the programs themselves were starting to unfold. The NPO underwent personnel changes; increased activities and leadership at grantee sites began; the Foundation accepted more unusual funding requests; and communities were realizing the power of their voice in the battle with alcohol and illicit drugs. Mutual and bidirectional learning and changes were unfolding and being exhibited.

Grantees held meetings every six months. These three-day gatherings afforded the grantees the opportunity to be together as well as to teach about, demonstrate, and become familiar with the projects and activities at other sites. These meetings were very structured and busy, often extending well into the

evenings. Each meeting had a theme, and many of the grantee site directors contributed to the programs. Poster sessions and workshops were common. A few of the meetings were held at grantee sites, mostly the urban or larger areas. These meetings offered a unique insight into the challenges faced by the local grantee. Grantee meetings were often attended by new personnel and tribal representatives each time. The personnel changes among the sites constantly altered the attendees and, therefore, the historical understanding at the meetings. The NPO, NAC, and a grantee meeting program planning committee of site directors worked hard to provide a meaningful experience.

Evaluation of Healthy Nations was a late arrival in the process. Initially conceived and pursued through an individual Request for Proposal, no evaluation contract was awarded by RWJF because the proposals submitted were deemed too complex and particularly too expensive. The exclusion of a prospective evaluation component, designed and executed from the beginning of a Foundation program, was unusual. Rather than citing the complicated nature of the submitted evaluation plans and proposals, other explanations were offered. One such explanation was that Native groups had been researched and surveyed extensively, and it was felt that mandating baseline data and having the specter of assessment and judgment hanging over the programs would inhibit the formation of natural processes. Nevertheless, the idea of measuring or evaluating the effectiveness of the investment never totally disappeared.

Norm Dinges, Ph.D., was hired in 1995 to serve as the HNI historian, writing project narratives from selected sites. Dr. Dinges attended a number of

the semiannual gatherings and made targeted site visits to witness these programs developing. His role as the narrator was well-accepted by the local HNI personnel and tribal organizations as well as the RWJ Foundation, NPO, and NAC. Nevertheless, the absence of a formal evaluation plan combined with the history of excluding an evaluation requirement and expectation remained a frustration to the NPO, NAC, and some of the HNI sites that preferred their efforts (especially successes) documented in a clear and defensible manner.

Late in Phase II, around 1999, the Foundation and NPO sought formal proposals to complete a retrospective, quantitative analysis of social and health measures as well as a qualitative formative evaluation. The intent was to identify and, if possible, measure the effect of the prevention programs on behaviors and health status. The qualitative piece was to carefully document the mobilization processes, the development of community infrastructure, and the evolution of the program components. It was the strong consensus of all involved that history was made in six years of the HNI evolution. A three-year evaluation plan was let to the University of Alaska Anchorage's Institute of Social and Economic Research; in turn, the quantitative and some consultation parts were contracted with the University of New Mexico's Center on Alcoholism, Substance Abuse, and Addictions. Most of the sites had unexpended funds allowing for a program extension that facilitated a limited participatory nature for the qualitative evaluation. The rest of the evaluation process is history, as told in the preface.

The Healthy Nations Initiative was similar to Improving the Health of Native Americans but still different from any historical Foundation grant. The

flexible substance-abuse-targeted structure that afforded tribal entities and HNI program staff to move ahead without a formal evaluation program was outside the usual RWJF protocol. The supportive nature of the program, which encouraged cultural and traditional activities to be central in the execution of the grant, demonstrated sensitivity and innovation. This belied the more prescriptive structure of most large program and research models. The gathering of experts was not atypical, but the interaction over the life of the grant demonstrated a mutually informative relationship. Although the NPO acted as the primary administrative unit for Healthy Nations, the Foundation maintained considerable involvement and attention to the project. As the HNI matured and evolved, all parties (tribal, NPO, NAC, and RWJF) seemed to embrace greater flexibility, particularly during the final two years. This can be partially explained by the cultural intersection between tribes and the Foundation. As the programs implemented true community-wide and -informed components to Healthy Nations, the Foundation and NPO were faced with recognizing and funding activities and programming not anticipated nor previously experienced. This reflects the action of the whole program across all sites and programs. The relationship between parties was different from the usual information transfer and data analysis.

Robert Wood Johnson invested $13.5 million into community mobilization in Native American reservations and organizations to address the problems of substance abuse. From the tip of Alaska to the Smokey Mountains of western North Carolina, along the Plains Rivers, in the high deserts, and in several urban

settings, Native communities enjoyed the attention and support of one of the strongest and most reputable health institutions in the world. Healthy Nations produced many offshoot programs and activities, helped to train and support local personnel, and lent the grantee sites the prestige of having been associated with the Foundation. Most importantly, Healthy Nations became a name filled with hope, power, and respect. A movement had started. These fourteen sites all have remnants of Healthy Nations currently active (2003), and the Foundation itself will long remember the innovation known as “Healthy Nations.”

Central Council of Tlingit and Haida Indian Tribes of Alaska

Juneau, Alaska

Healthy Nations Program

December 1993 – January 2000

“All connected in the Circle: From Regional to Local Ownership”

Central Council of Tlingit and Haida Indian Tribes of Alaska Narrative

Historical Context:

The Central Council of Tlingit and Haida Indian Tribes of Alaska are located within 43,000 square miles of the spectacular panhandle of Alaska, also known as Southeast Alaska. This region lies along a 550-mile strip of coastline and inland waterways and includes many island communities south of Anchorage. It is inhabited by three major indigenous peoples: the Tlingit, the Haida, and the Tsimshian. These groups are organized along clan membership lines, enjoy unique cultures, and have distinct language roots.

Juneau, Alaska, is the largest of the communities in Southeast Alaska. It is the headquarters of the Central Council of Tlingit and Haida Indian Tribes of Alaska. From this central location originate most services and resources, including services for the Tsimshian tribe. The Central Council was officially recognized by the federal government in 1965 by an amendment to the 1935 Jurisdictional Act. Some 25 years earlier, in 1939, the Tlingit and Haida Central Council was organized by resolution at the Alaska Native Brotherhood convention. Governmental action is executed by the General Assembly; a body of 21 community representatives that elects a nine-member Executive Board. The General Assembly elects the President who chairs the Executive Committee and is the Chief Executive Officer of the Central Council. This organization allows for representation and coordination with the diverse and distant communities. Southeast Alaska includes approximately 20 different communities and villages,

each having a local complex of governmental systems made up of city governments and Indian Reorganization Act Tribal Organizations as well as other federal and state agencies. The Alaska Natives Claims Act of 1981 permitted the creation of Sealaska, the for-profit corporation which manages resources and provides economic opportunity to the region. The Central Council formed the non-profit authority providing health and social services and partnering with the Southeast Alaska Regional Health Corporation (SEARHC). This organization provides most of the direct services throughout the region. Centralized medical and social services are managed under SEARHC. This organization provides general medical, dental, mental health, and substance abuse outreach and other social service supports to each of the different communities. SEARHC works with village health clinics and community prevention coordinators in those communities that have such facilities.

Service delivery is complicated in this region due to transportation difficulties. Because there are no roads between most of the communities and travel is complicated by distances and weather, face-to-face contact is difficult to schedule and conduct. Travel necessitates either using the Alaska Marine Highway, a ferry system navigating the inside passage of the North Pacific which is time consuming, or small aircraft travel which increases the cost and risk. This poses challenges in directly supervising each village. Although each village is currently connected by telephone and electronic conveyance, it is still necessary for program management and service providers to have direct access to the leaders and personnel in the communities. Geography creates a unique

dimension to program implementation and success. The ability to respond to the prevention and treatment needs as well as to negotiate each different subculture and government had continued to challenge any broad-based initiatives.

At the beginning of Healthy Nations, the enrollee population was approximately 21,000 tribal members, with 16,000 of those living within the service area. In addition to the vast geographical distances and community isolation, Southeast Alaska exhibited disproportionate-level personal and cultural effects of substance abuse. The problems surrounding alcohol and substance abuse are well-known and documented in the Alaskan Native populations. Particular to Southeast Alaska, as cited in the 1992 Central Council's Substance Abuse committee assessment, five of the top causes of death are substance-related. The statistics generated by regional treatment facilities indicate that on any given day over five percent of the catchment population is in treatment for substance abuse. This is twice the national average and generally regarded as severely insufficient to known treatment needs. The 1992 "Health and Social Service Needs in Southeast Alaska—A Household Survey" stated that, "Alcohol and drug abuse is by far the most pressing health and social service concern in Southeast Alaska . . ." In 1992, Hoonah, an island community but representative of the many other Southeast Alaska communities, reported that 44 percent of emergency medical service calls were directly alcohol-related. Other indicators that point to the significant difficulties caused by alcohol and substance abuse relate to the criminal justice statistics. The data reported in the proposal cite that the arrest rate for Native juveniles is nineteen-to-one non-Native in Juneau and

four-to-one in other outlying communities like Petersburg. Officials cite substance abuse as involved in a majority of these arrests. Other stark data cited indicate a suicide rate six times that of the national average, with the young Alaska Native males, ages 20-24, rising to twelve times the U.S. rate. Most of these avoidable deaths were alcohol-related. It is understood in the region that most Native families have been negatively impacted by substance abuse. The Central Council and concerned organizations and individuals have engaged in different programs to address this problem.

Phase I:

The Phase I proposal, “Circles of Support for a Healthy Nation,” was produced by a coalition of providers and agency directors. Under the direction of delegate assembly and the executive committee underneath the office of president, this substance abuse committee was created. This committee sought to address substance abuse prevention utilizing previously organized activities as well as attempting to coordinate the diverse community and centralized responses to substance abuse within the region. This was the driving force behind the Phase I grant proposal. Upon grant award, the “Circle of Support” was strategically located within the office of president in the Central Council. This allowed for the program to maximize the authority and weight of the president’s office to bring about a comprehensive initiative that would address the effects and damage caused by substance abuse. The favorable placement in the organizational chart also ensured access to otherwise disinterested or

removed programs and resources within the Central Council. The Council President was a strong advocate for the “Circle of Support” and helped to secure $60,000 in direct local funds and authorized many in-kind contributions. This initial access to the office of the President proved important in maintaining the momentum throughout the Initiative.

Phase 1 began as a pilot demonstration program with the explicit hope of being able (1) to help increase local resources by supporting local substance abuse counselors in each of the communities, (2) to create a network of treatment and service providers through better communication, and (3) to increase pubic awareness through a concerted use of public service announcements, calendar coordination, and gatherings to teach about the ills of substance abuse within the context of tradition and culturally relevant activities.

Early in Phase I, the public awareness included a contest, open to the public, to suggest a slogan. The winning entry was “Together We Can” submitted by a person in Saxmon, Alaska. From this motto, a logo design was selected which depicts “Together We Can Do What We Cannot Do Alone.” This was placed on tee shirts and posters and used as part of the ongoing public awareness project during Phase I. Such giveaways and advertising media served to increase name awareness and send the message of wellness sponsored by the “Circle of Support.”

Two pilot communities were initially chosen because of the extensive leadership mobilization and adequate infrastructure development. One was Juneau, with the largest population and also the greatest infrastructure of

community agencies. The other was Hoonah, selected because the community had a planned approach to a health delivery model that was up and running. Members of the Hoonah community had already identified drugs and alcohol as the most important program concern. With these selections, following the receipt of the funding from Robert Wood Johnson, the Central Council hired a project director who remained throughout Phase I. Also, the community prevention coordinators at these two sites were recruited and employed as “Circle of Support” staff. At this time, numerous public awareness campaigns were also initiated. Early success followed the establishment of the “Circle of Support.” The first major public awareness campaign was a back-to-school readiness giveaway. Here anti-substance abuse and positive wellness and health messages were combined with giving away school supplies and backpacks to kids going into elementary school. This was a tremendous success involving an unanticipated 700 participants.

Consonant with the goals of Healthy Nations, “Circle of Support” began by organizing a regional circle from the agency directors and representatives from the different communities. They were charged with discussing the overarching philosophy and planning of activities. One result of these discussions was the creation of local circles, including the Juneau Circle; these local circles were to deal with local issues and mobilize local community leaders and volunteers. These local circles became the mechanism by which Phase II activities were to be advertised and managed.

Early coordination success within the Juneau Circle helped develop a kid's calendar and a handbook for youth counselors. This document gave basic activity descriptions and suggestions as well as information regarding an August Youth Conference that was held in Phase I. Other local circles worked within the regional circle of support and started to develop and identify areas of volunteer activities and areas of concern for each of the communities. The enthusiasm and vision of this project stretched the abilities of the director and resources. With so many items and projects in the developmental state, many good ideas were only partially supported. The administrative assistant depicted this period as a "rush to meet each one of the different components as outlined in the Robert Wood Johnson Grant Proposal." This rush consumed the emotional resources and obscured the needed focus of those associated. Such overwhelming demand and response unveiled the depth of the problem and hurt. The staff and leadership became aware that Healthy Nations carried such important implications and possibilities for all different communities. At times, actions preceded planning and integration, setting the program up to some frustration and staff struggles.

Transition:

The transition into Phase II was punctuated with concern about compliance to the reporting regulations and adequate addressing of the grant components. The NPO had convened two site visits in the first Phase. The focus of these meetings was to provide encouragement and technical support to the

director regarding more complete representation of the activities of the grant. Inconsistencies in describing the efforts of the staff and the responsiveness to the philosophy of Healthy Nations were identified areas of discussion. This pressure and intense production of activities as well as other employment opportunities led to the resignation of the first program director. Occurring at the junction between Phase I and Phase II, this disrupted the development of the Phase II proposal. The Substance Abuse Committee was forced to assume responsibility to respond to the call for the Phase II implementation proposal. They responded and submitted a proposal including goals and objectives that were based on the previous two year's work. The proposal underwent two iterations and finally met the approval of the NPO. Correspondingly, a new director was hired concurrently with receipt of notice of award for Phase II. The tenure of this director was just months. Reminiscent of the end of Phase I, the first year of Phase II implementation saw new projects disrupted by leadership changes and the re-interpretation of the grant.

Phase II:

Activities that had started early in Phase II bogged down or were lost with personnel changes, especially those in leadership positions. Projects such as more youth conferences, the expansion of prevention coordinators into six different villages, the release of greater public awareness effort, and the development of culturally sound treatment networks were interrupted. Such difficulties in maintaining direction and personnel caught the eye and concern of

the NPO. In the first two years of Phase II, conversations with the NPO centered on encouraging the Central Council to follow their grant plan as well as helping to bridge the leadership problems. A period of confusion, loss of momentum, and program stagnation defined the middle years of Phase II. Two more directors were hired, both of whom vacated their employment for varied reasons after short stints. The revolving personnel cycle increased challenges and barriers to the development and maturation of the “Circle of Support.” Finally, the leadership crisis was abated by hiring a proven leader who provided stability and longevity through the end of the grant cycle.

Early in year three of implementation, a conference on Native values for youth was held. This was a three-week youth conference focusing on cultural values and traditional understanding. This conference featured Elders, the Alaska Native Brotherhood and Sisterhood, and other local leaders from Juvenile Justice and Juvenile Court. Attended and supported by other agencies that provided inpatient, outpatient, and aftercare services as well as outreach, the conference was a success. Over 100 young people attended this conference, 24 percent of whom were court mandated. From this Native Values Youth Conference emerged the shining star of the “Circle of Support” program—the Drum Dancer Group. This group helped to solidify the philosophy and direction of the remaining grant period.

Highlights:

Comprised of court-mandated, at-risk youth, the Drum Dancers were taught by Elders about Native dances and drumming. Connecting the youth to the traditions and pride of their culture demonstrated protective and healing strength and became a privileged opportunity. This group functioned for almost three years and received numerous awards, including the peer leadership award. They were invited to the Alaska Federation of Natives meeting in Anchorage and were awarded the Spirit of Youth Award. These youth, through their participation, became leaders in their community, helping to delay their peers' entrance into gangs and substance abuse. Eight of the youth went to college; four went to vocational school; and none of them returned to their life of problems. This was a high point and a time for celebration for Healthy Nations. The program involved families, including grandparents, who would come to the performances; the greatest advocates and supporters were the Juvenile Justice Court officers, police officers, and especially, the Juvenile Court judge. This connected the community bridging the Native and non-Native sectors. The partnerships formed in Phase I found maturity and depth in supporting this group of youth. Drumming and dancing signaled a renaissance of cultural awareness and pride for these youth, mechanisms of social repayment through the courts, and recovery medicine for substance abuse.

Healthy Nations was also quite successful in producing two videos: one, entitled "Carved from the Heart," dealt with grief and healing in a Native community; another focused on youth parenting. These videos were high points in the public awareness campaign. Although there were political and production

squabbles, the finished products carried a strong cultural message and demonstrated important skills. The public awareness campaign created many announcements on radio and television. Added to the many printed media, this campaign was the invitation to each community to participate in “Circle of Support” activities. The campaign covered topics including fetal alcohol syndrome, inhalant abuse, positive parenting, culturally relevant issues, and healthy lifestyle messages. Coordination and publication of the community calendar was a central responsibility of the director and staff. Managing the scheduling of the multiple events helped avoid having overlapping meetings and diluting public attendance. The last two years witnessed a significantly smoother and more productive coordination of services as well as a strengthening of coalitions. Such coordination efforts brought together professionals, elders, youth, law enforcement, and city officials, all now sharing their willingness and expertise in prevention and treatment. One component of the public awareness campaign included stories in local papers, free advertising in corporation newsletters, and feature spots and articles in regional newspapers that highlighted the program’s successes and conveyed valuable cultural wisdom. Public recognition of the staff and participants served to reinforce positive behaviors and encouraged other organizations to undertake similar activities.

“Circle of Support” was quite successful in organizing conferences and training opportunities. One such successful conference was the Native Protocol Meeting. This gathering provided an opportunity to help non-Native and uninitiated Native youth and adults with understanding the different Native culture

protocols. The conference featured speakers and Native leaders who explained the spiritual and ceremonial systems within the different cultures, traditional living, and cultural understanding about health and wellness. This conference was unique and very effective. Drawing in over 500 participants, this conference reinforced the hope and effort to have Native traditions and values become the foundation for treatment and living throughout the region. Training professionals in the arts of traditional healing and understanding of cultural ways proved to be quite successful and consistent with the philosophy of “Circle of Support” and Healthy Nations.

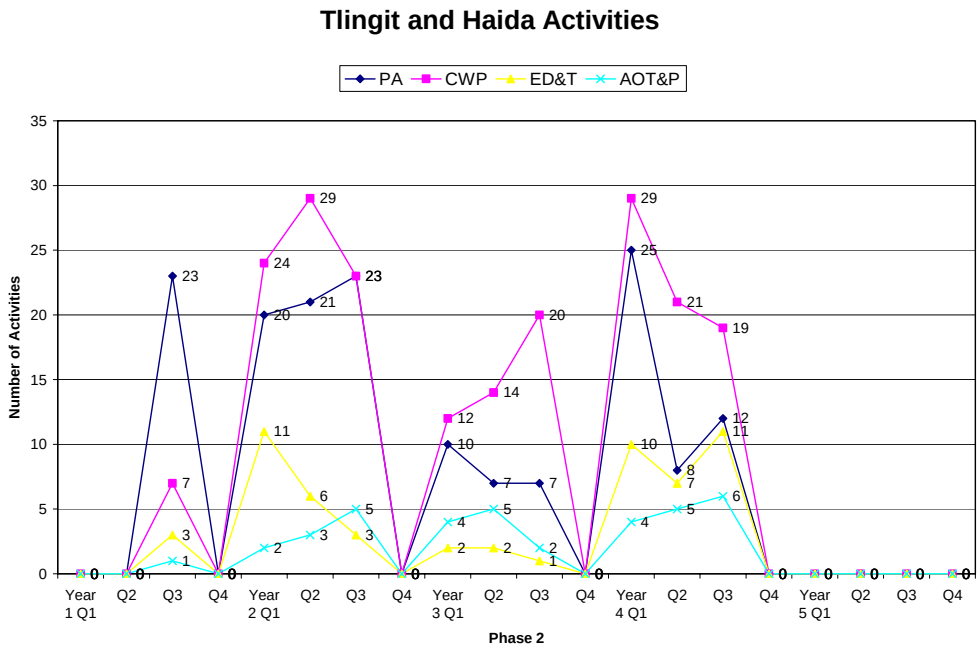
This period of grant success was not without its struggles. Different communities clamored for a greater portion of resources without demonstrating sufficient mobilization or infrastructure to execute their ideas. Complaints were issued about centralization being in Juneau and the problems in gaining access to resources and staff. Travel became burdensome for the director, coordinator, and activities outreach individuals. The sheer number of programs that were sponsored or co-sponsored by Healthy Nations began to blossom. Burnout and overwork were constantly haunting the staff; internal politics continued to arise. Different political and program sectors proposed alternative activities and uses of Healthy Nations funds. These were agency driven and different from those that had been developed from the community and from the different local circles, increasing stress in the final stages.

Adding to the pressure was the failure of a highly touted gathering. The staff had planned a Spirituality Conference as the final gathering, hoping to

crown their experience with Healthy Nations. They anticipated this would launch the foundational ideas and good works into the future. After great labor, much anticipation and organization of bringing in Elders from across the region, and having many positive activities ready, only 50 people attended. This was quite a disappointment and seen by the staff as a letdown.

Many of the philosophies and ideas central to the “Circle of Support,” such as networking, community calendaring, provider coordination, and the community-based local circles which included volunteers and coordinators, have been taken into the future. Federal funding administered by the Alaska Federation of Natives, called “The Tribal Wellness Program,” has sustained the Healthy Nations philosophy and many of its programs for over two years. The last director of “Circle of Support” is the director of the Tribal Wellness Program and continues implementing the Healthy Nations ideas and spirit. This new program is described by the ex-director as Phase III of Healthy Nations. It, too, is supported by the current Central Council President and tribal committees, partly because of the successes of Healthy Nations. Activities and programs that had been sustained by the “Circle of Support” such as the annual Sobriety Walk, at-risk youth diversion programs, and cultural awareness symposiums remain institutionalized through other funding sources and administered by different organizations. As the ex-director said, she wishes to thank Robert Wood Johnson for learning to grow in flexibility over the first few years. It allowed them to respond to the communities in such a way to initiate long-term changes. She anticipates such changes and successes will continue as this new generation,

touched by Circle of Support, grows into maturity and gives back to the community.



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Cherokee Nation of Oklahoma

Tahlequah, Oklahoma

Healthy Nations Program

December 1993 – December 2000

“The Rising of a Generation of Prevention Initiatives Born from Strong Ambition and Faithful Vision”

Cherokee Nation narrative

Historical Context:

The Cherokee Nation is a non-reservation site that covers approximately 9,200 square miles in Northeastern Oklahoma. Due to government-sponsored auctions and land-grab settlements, the tribal land currently covers only two percent of the land set aside prior to 1907. Such actions severely fractured the sense of community. Unlike most reservations, the tribal lands are known as the Cherokee Tribal Jurisdictional Statistical Area (CTJSA). This geographical entity is comprised of all or part of fifteen Oklahoma counties: Cherokee, Adair, Sequoyah, Delaware, Mayes, Nowata, Craig, Rogers, and parts of Ottawa, Bartlesville, Washington, McIntosh, Wagoner, Tulsa, and Muskogee. The CTJSA also overlaps into parts of eight other counties. The tribal seat, Tahlequah, is the historical end of the “Trail of Tears” and is where the tribal government manages services, laws, and intergovernmental relationships. This tribal seat and these administered lands are not the historical home of the Cherokee.

The Cherokee history is replete with forced relocations and loss of ancestral lands, broken treaties, and forced marginalization from the dominant culture. Although one of the original civilized tribes and unique in the development of written language, education, governmental structure, and social functioning, the Cherokee were subjugated and denied basic liberties and sovereign rights until the 1930s. Today, the Cherokee area has an undefined

intersection with the non-Native population and is diffused among numerous communities—many with fewer than 500 people.

The interruptions of culture, community, and traditional lifestyle created and perpetrated by land loss have, like other American Indian and Alaskan Native groups, posed burdensome disadvantages for the Cherokee Nation as they respond to modern society. Responsible for over 102,000 American Indians, of which 87,000 reside within the Cherokee TJSA, the tribal government faces tremendous challenges in providing services. The tri-partite government consists of the Principal Chief and the Deputy Chief, who make up the Executive Branch; fifteen council members, elected from the population, who constitute the Legislative Branch; and a Judicial Appeals Tribunal. Four main service divisions of the government provide daily operations of the tribe: Health Services, Social Human Services, Community Development, and Marshal Services and Law and Justice. At the beginning of Healthy Nations in 1993, there had been only three Principal Chiefs in history since the official tribal government reorganization in 1975.

The Cherokee Nation has faced and experienced the devastation of alcohol and drug abuse. Although recognized for decades as a serious problem, physical survival and tribal existence consumed leadership attention and tribal resources. A few outside agencies and programs, primarily Indian Health Service, existed prior to 1986. Their distribution of services and effectiveness were quite uneven and lacking in community support. These programs were, at times, of questionable quality. As the tribal government grew more sophisticated

and more organized, needed attention to the substance-abuse problem increased. In 1986, the Omnibus Drug Act focused resources and governmental action on this pressing problem. The following year, 1987, the Cherokee Nation published their Tribal Action Plan, a blueprint for development, growth, and health that proved an historical turning point for the tribe and the communities. Substance abuse and alcoholism were being recognized as significant factors in many of the problems on the reservation and were demanding resources.

The extent of the problems were intuitively understood by tribal leadership and confirmed by numerous research and survey projects. The data reflected the pattern of unchecked personal and collective damage wrought by substance abuse. During the early 1990s, the American Drug and Alcohol Survey conducted with 9th-12th-grade Oklahoma students revealed that Cherokee students had nearly a double rate of reported use of alcohol and illicit drugs. In 1992, the tribal marshal services indicated that 90 percent of calls were related to substance abuse. The Community Health Service data noted that a significant portion of the severe injuries reported were alcohol- and drug-related. Lastly, research cited that four of the five leading causes of death of Cherokee Nation's tribal members were connected to alcohol.

Complicating the assault of substance abuse was the diffuse nature of the catchment area and the lack of cohesiveness in some of the communities. Over time, many communities had accepted substance abuse as normative. This further challenged the growing but rather centralized cadre of services. Having documented what was commonly known, the tribal government established an

outpatient counseling program with substance-abuse-specific outreach services. Added to the group of services was the Jack Brown residential treatment center. This youth-focused center acted and continues to serve as a primary mental health and substance abuse facility in the area. The staff provided ongoing training for professionals working with Indian Youth. The tribal programs, situated within a greater matrix of Community Health Services, continued to be fragmented and without sufficient personnel or resources to adequately service all the rural communities.

Partnering with the state social services departments, the programs for women and children, and the housing authority, the concerned providers and leaders acknowledged that the magnitude of the problems outstripped their limited resources. The rapid deployment of services, the conflicting demands of different funding sources, and the lack of coordination added to service fragmentation and uneven effects. In response to the Robert Wood Johnson Foundation call for proposals, three committees representing different tribal programs were formed. Staff from the Children, Youth, and Families Committee, clinical staff from Jack Brown Treatment Center, and representatives from the tribal health services gathered to write a Healthy Nations proposal. Members of these three committees acted as an advisory board during the early stages of the Cherokee Nation Healthy Nations program. They established the direction and philosophy of the Healthy Nations that paralleled existing tribal programs. The proposal reflected many of the trends and structures found in the tribal health system. The submitted proposal embraced greater community participation in

prevention as well as more local access to services. Culture and coordination were strong components in the proposed model. Cherokee Nation was awarded the Phase I planning and development grant. The tribe began structuring the program and hiring staff.

Phase I:

The advisory committee had composed a proposal positing greater coordination and access to services as the central tenet of their efforts. They theorized that such connections and coordination would stimulate consumer usage, provide greater support to families, and increase efficiencies. The proposal writers envisioned stronger community involvement and, therefore, increased mobilization against substance abuse. Traditional family values, cultural ceremony, and traditional recreation formed the foundation philosophy for the Cherokee Nation Healthy Nations program. Early challenges to this ideal of integrating and mobilizing the diverse communities within the Cherokee Nation catchment were manifest in the logo development and early Phase I activities. Disagreement of a stylized logo representing modern depictions countered the more traditional and ceremonial images. The resolution of the logo issue foretold of the strength of tradition. The energies necessary to reconcile and accommodate the various sub-populations and their traditional beliefs would be evident and surprising throughout the life of Healthy Nations.

Organizational placement in the Behavioral Health Unit of the Tribal Health Division exerted pressure on the direction and philosophy, both positive

and restrictive, of the developing Healthy Nations program. Many associated tribal programs viewed Healthy Nations as a source for expanding their services. Leadership and management of the new grant were central in the jostling for responsibility and control. A vibrant young director was hired. This director of the Healthy Nations program at Cherokee Nations dedicated herself to the program and concepts while thrown into negotiating the tribal and intra-agency politics. She was the only director of the program at Cherokee Nations during the entirety of the Initiative. This was a unique feat and produced prodigious outcomes. As the Healthy Nations program matured, many of the initially supportive tribal agencies and programs systematically shifted away from direct association and coordination.

The loss of internal support and relationship fostered greater outreach and association with non-tribal agencies. These relationships consisted of working with the Housing Authority of the Cherokee Nation, community health clinics, and community public school systems. Healthy Nations leadership divided the task of negotiating these relationships between the coordinator and the health educator. The coordinator was responsible for the intra-tribal relationships while the health educator attended to the outside collaborations. These assignments reflected the strengths of the staff's individual styles and capabilities. The arrangement functioned well in mobilizing resources and communities in the early phase, but this leadership arrangement was not without conflict. Personality differences created stress. The health educator eventually left the position, and hiring a replacement posed the first of many important negotiations with the advisory

committee and identity development for Healthy Nations. The coordinator's concept of job qualifications embraced the natural leaders and empowered the community through informal connections, while the advisory committee was more committed to the professional qualifications and IHS model of hiring.

This early tension set the stage and philosophy for the rest of the Healthy Nations programming. The resolution leaned in the coordinator's favor, supporting the qualities of identifiableness, community savvy, and non-threatening status. A compromise was struck. The new hire had previous tribal agency experience while having positive community rapport. This left the advisory committee with dissonance and doubting the wisdom of the coordinator and the philosophy of Healthy Nations.

Fortuitous events came together to provide Cherokee Healthy Nations the position and strength needed to complete their tasks. Tribal administration reorganized the Tribal Health Division and created the Health Promotion and Disease Prevention Department of the Health Division. Eventual placement of Healthy Nations in this organizational slot virtually halted the advisory committee's recommendations to have it subsumed under an ongoing CSAP grant. Tension between the advisory board and the Healthy Nations staff continued throughout Phase I. Attempts to quell the tension included accommodating the committee's choice of communities for the initial pilot projects. It soon became clear that this chosen community lacked enthusiasm and acceptance. The community was not ready. Lessons about community readiness and willingness were presented early. Worries about the flexible nature

of the grant, the dedication to community response, and the unorthodox hiring requirements manifested the advisory committee's ongoing discontentment with the direction of Healthy Nations. They attempted to micro-manage the program application and consistently over-analyzed the coordinator's decisions. This arrangement consumed much of the coordinator's energies and did little to present a united philosophy to the communities. Fortunately, the executive director of the Health Department was quite supportive and provided resources and permission to the coordinator. This relationship allowed the pilot programs to advance and take hold. It also saved the coordinator from abandoning the position.

Following the first grantee meeting, the Healthy Nations staff returned more dedicated to the community empowerment model, which represented a significant and crucial turning point in the trajectory and mission of Cherokee Healthy Nations. The staff made deliberate decisions to approach receptive communities and capitalize on existing staff/community relationships. They targeted Adair County, a significantly Cherokee area. Invitation to provide curriculum in the schools and coordinate culture activities with the students was gradually accepted. This success garnered attention and, ultimately, a strong coalition with the area Housing Authority of the Cherokee Nation. Together they sponsored the "Nativefest" or "Native Games," aimed at 8th graders in Adair County. The many contributing agencies—including Cherry Tree Community, the Crime Prevention League, and others—felt that the event was quite successful. The effective and positive reputation of Healthy Nations increased visibility and,

therefore, increased requests to help other communities. The strength and desirability of Healthy Nations was augmented by their ability to respond to the community with both time and resources. This was different from most tribal and governmental programs.

Accompanying this early success was a sore personnel issue that pulled energies from the program and added to the stress of the young coordinator. Besides nagging personnel issues, there were the impending tribal elections. Supposed association with a successful program like Healthy Nations carried into the election rhetoric. The Healthy Nations staff decreased visibility and remained neutral to avoid the divisive nature of politics. Notwithstanding the staff's effort, Healthy Nations was co-opted into candidate debates and platforms.

The net effect of the elections was a new Principal Chief and the consequential changes in leadership in the major divisions of the tribal services. Fortunately, the coordinator survived, but one of the early programs was permanently disrupted due to perceived political alliances of Healthy Nations, severely detracting from fulfilling objectives in Phase I. This period of development proved that the philosophy of "community first" and supportive listening by the program staff leads to success and influence. The construction of a strong Healthy Nations program going into Phase II implementation confirmed the vision and dedication of the staff. The barriers and challenges had shifted the composition of the advisory board and created greater outside alliances. The transition into the implementation stage of Phase II was prepared on solid footing.

Transition:

Phase II began where Phase I left off. The implementation proposal expanded the pilot programs into six counties and then to all Cherokee communities. A strong public awareness component, in-school education and traditional teaching, along with resource allocations to communities and continuing attempts to bolster the treatment and aftercare community defined the objectives and energies of Phase II. The transition was not completely seamless or without disruption. The election had installed a new health director with a different stance toward Healthy Nations. The previous supportive relationship of the first health director gave way to a stance of toleration and increased supervision. The new management had changed the financial reporting and request process, which posed a problem and roadblock in the flexibility of spending and responsiveness to community requests.

This change in internal support and the disruption of the election had negatively impacted the Healthy Nations effort and reporting. The accumulation of these factors and the nature of the transition process necessitated a NPO site visit. This meeting was interpreted as edgy and threatening. The coordinator was suffering from burnout and over-commitment. The ecology of the organization was undergoing shifts, and demand for Healthy Nation services grew. Reporting had suffered and the complicated financial requirements strained, appearing as non-compliant. The site visit provided a clarification of the grant demands and a

strong message of meeting the proposal components. This meeting both stressed and supported the Healthy Nations staff.

Phase II:

The coordinator described Phase II as “going from pushing down walls to being pulled on roller skates.” The Phase I internal detractors had diminished in influence, and Healthy Nations enjoyed a strong identity. Healthy Nations was growing in reputation; demand for support was accelerating; activity planning and implementation was brisk; and the staff was working 70 hours per week. The tribal reorganization posed challenges but failed to deter the direction and expansion of Healthy Nations. Even Healthy Nations physical space demanded adjustment when they moved from the central Health Services office to a new location. Initially thought of as a political carryover, the move allowed a more casual environment and provided flexible hours and greater public access. The move corresponded in time to a summer fitness camp sponsored by Healthy Nations, which taxed available resources. However, the staff rose to the occasion, and this initial camp set in motion a defining activity of Healthy Nations.

Early Phase II saw changes in financial accounting as well as a new attitude and vision of the Health Department director. This new health director was supportive but failed to produce promised resources and personnel, although the Healthy Nations staff was maintained on the tribal payroll and not financed through the grant. For example, a problem arose around purchasing tee shirts for participants. The director thought such items were superfluous and

wasteful; the program staff thought they were essential and productive. The Healthy Nations staff, through persistence and negotiating various administrative demands, continued to send the message of traditional pride and health via tee shirts and giveaways.

Phase II was extremely busy—a period of tremendous expansion, including a successful public awareness campaign, involvement in numerous schools, and sponsorship of both traditional and health-related activities. The coordinator matured further and found boundaries to her dedication. Difficulties in addressing all of the grant objectives again caused NPO concern. Successes were insufficient to balance the weakness in addressing early identification and enhanced treatment options. Notwithstanding the holding of monthly coordination meetings, the intra-tribal collaboration continued to be rocky and created barriers to fulfilling these components. The Healthy Nations staff was hesitant to refer individuals to treatment, considering it outside their expertise. The coordinator recognized this gap and addressed these grant objectives through training for the Healthy Nations staff on substance abuse recognition and assessment, and the latter years of Phase II reaped benefits from this decision. Healthy Nations staff became more involved in identifying at-risk community members through participation in community activities. The relationships and reputations built on these successes allowed referral and better coordination with some of the treatment facilities.

The grant experienced one more structural shift with another change in health directors. It resulted in thwarting some goal attainment and causing delays

in new program efforts; however, the coordinator effectively addressed and resolved these problems. Healthy Nations continued steadfast in its dedication to community empowerment and traditional activities as essential to prevention and wellbeing. Weathering numerous internal and external storms, the staff demonstrated the courage and belief to endure. The successes and legacies of Healthy Nations witness to these attributes.

Highlights:

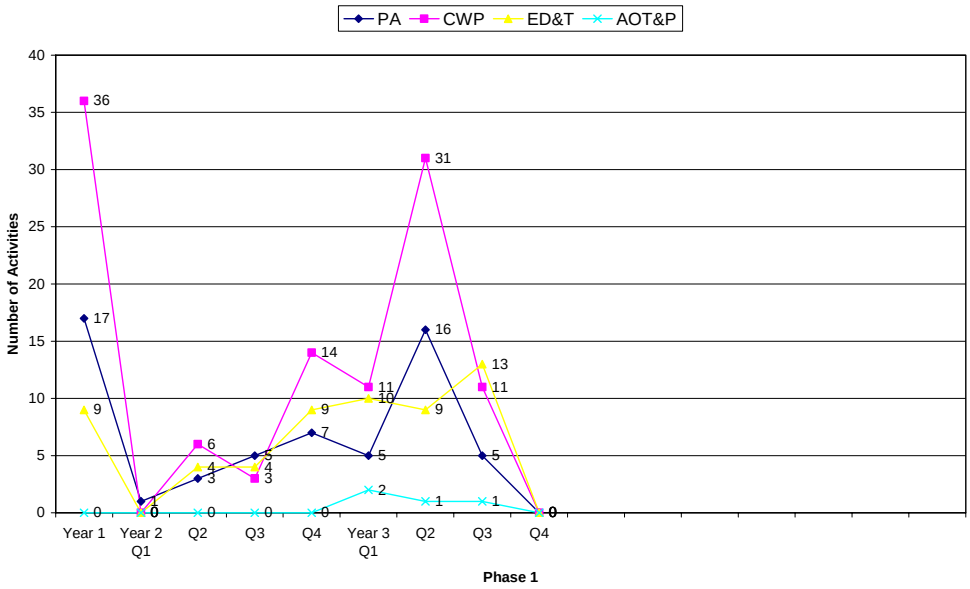
In-school education and prevention is one hallmark of the Cherokee Healthy Nations project. The original success in Adair County expanded to numerous other schools. The school acted as the cultural and community gathering place, and alliances with teachers, principals, and students facilitated entry into other functions and groups within the different communities. The Healthy Nations curricula and programs disseminated health messages, taught parenting skills, identified at-risk kids, and instituted a fitness program. These relationships continued to provide an entrance into the community. Following the end of the grant, the in-school prevention and skill development programs were assumed by a HUD grant for drug-free communities in collaboration with the now-tribal-operated Healthy Nations. Other agencies and cultural committees have been invited into classrooms to teach and support the teachers and students. Youth groups, video clubs, fitness groups, and cultural committees all take their beginnings from this hallmark program. Today, teachers and school administrators inquire if Healthy Nations support is still available.

Cultural activities and the revisiting of tradition served as preventive and restorative factors in the stomp dances and other tribal events sponsored by Healthy Nations. Powwows and gatherings were supplied with measured resources and materials to augment the participation of sober youth and adults. One of the most notable successes is the “Wings” program. Many health indicators showed that the Cherokee people were physically at-risk because of lack of exercise, depression, and substance-related complications. Historically, running was practiced as a traditional activity and spiritual ceremony. The Wings program set out to reestablish the running tradition and, consequently, improved health status. From humble beginnings and marginal participation, the Wings program has engaged 1,300 tribal members in routine and frequent physical activity including running and walking. Healthy Nations strongly promoted and sponsored this activity, organizing and funding Wings events. It organized competitions and even supported individuals to run in state races. Tee shirts, trophies, mugs, and posters all encouraged both young and old to take to the roadways and run. When Healthy Nations funding ended, the Tribal funds, local schools, clubs, and businesses continued to sponsor this program. Today, it remains a vital community activity.

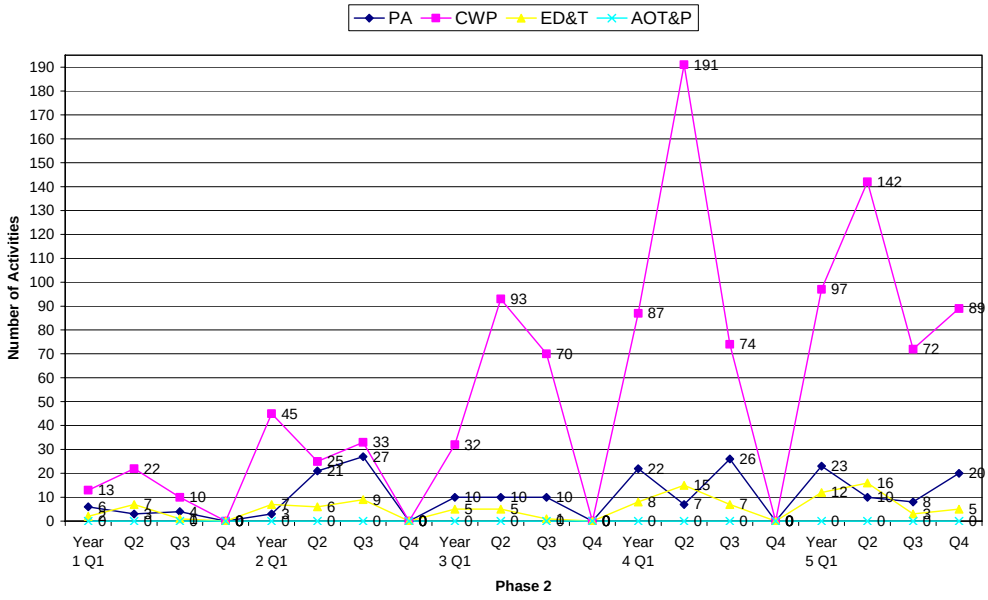
Each success at Cherokee seemed to be counterbalanced by some detraction from the goals and its full realization. The lessons learned in addressing these challenges promoted increased flexibility, leadership maturity and a more measured set of expectations. The development of the identity of Healthy Nations as a community-friendly and responsive organization became a

model for other service department reorganizations. The focus on prevention and the community collaboration philosophy remain central factors of associated service agencies and in the professional activities of those staff connected with Healthy Nations. Program personnel have continued to exert influence and exhibit healthy choices in the communities and agencies. Some Healthy Nations staff have completed university studies; others have taken roles as program leaders. Community volunteers supported by Healthy Nations remain change agents in their respective communities. Principles advocated by Healthy Nations have found resonance and a place in ongoing tribal and non-Native programs. Communities still call inquiring about support for healthy activities. Even the name retains power, recognition, and hope. Today, the Cherokee Nation Healthy Nations program is a health movement touching untold lives through fitness, education, information, and tradition.

Cherokee Nation Activities



Cherokee Nation Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Cheyenne River Sioux Tribe

Eagle Butte, South Dakota

Healthy Nations Program

December 1993 – October 2000

“From Research and Integrated Services to Horses and Culture: The Story of Prevention on the Plains”

Cheyenne River Sioux Narrative

Historical Context:

The Cheyenne River Sioux Tribe is one of the currently recognized five tribes of the Great Sioux Nation. It is located on the Cheyenne River Sioux Reservation in north central South Dakota. In 1889 Congress set aside 2.8 million acres for this reservation, which covers Dewey and Ziebach counties. It is one of five smaller reservations for the Great Sioux Reservation System. Four historical tribes constitute the Cheyenne River Sioux: the Minnicougou (plant by the river); the Itazipco (Sans Arc); the Siha Sapa (Blackfoot); and the Oohenumpa (Two Kettles). The Constitutional tribal government consists of a chairman, secretary, and treasurer—all elected at large—and 15 council members elected from 6 districts on the reservation.

Cheyenne River Sioux is a public law 96-638 compact tribe and is, therefore, responsible for law enforcement, criminal justice, health and human services, drug and alcohol treatment, social services (including welfare services), and in-home services for children. Tribal headquarters is located in Eagle Butte, South Dakota. There are 18 communities associated with the Cheyenne River Sioux reservation. Three communities are considered non-Native but nevertheless have close connections with the functioning of the reservation. The catchment area is home to approximately 12,200 American Indians, of whom

8,800 are registered tribal members. Eagle Butte is the host community for the centralized tribal services.

The Cheyenne River Sioux suffer from extreme poverty. Ziebach County ranked as the third poorest county in America in 1980 and seventh poorest in 1990. Data gathered through various sources suggest an undeniable connection between alcohol abuse and a higher-than-average mortality rate on the reservation. The 1985 Planned Approach to Community Health study underscored the severity and reach of the alcohol problems. The data revealed that more than one-half of the deaths on the reservation were preventable. It demonstrated a strong link between alcohol abuse and negative health outcome, including premature death. This confirmed a study of suicides between 1985 and 1990 in which all thirteen completed suicides were alcohol related; ten of the victims were inebriated at the time of death. Other surveys indicated that over 80 percent of the reservation's residents abuse alcohol. These studies pointed to binge drinking as the most prevalent method of abuse. Finally, expert witnesses have testified that the rate of fetal alcohol syndrome, held as one of the highest in the world, underscores the negative immediate and long-term effect of alcohol abuse.

Beginning in the late 1950s and extending to the early 1990s, tribal motivation to address substance abuse had been growing. Recognition that the costs, both in resources and in suffering, outstripped the capacity of the tribe resulted in instituting action plans. In 1985 the tribe intervened successfully in deterring the opening of two bars close to an Indian housing project, and in 1987,

the tribe officially declared “war” on alcohol abuse; goals were to establish an alcohol-free reservation by the year 2000. They took on more intervention programs, tribal strategic plans and actions—including tribal liquor control laws—and tribal court involvement. Many programs included collaboration with the Bureau of Indian Affairs, Indian Health Services, and other government agencies. The 1990s saw an increase in the creation of treatment programs and outreach services targeting substance abuse. These programs formed the foundation and structure ready to respond to the announcement of funding for the Healthy Nations Program.

At the time of the RWJF Healthy Nations call for proposals, many events intersected on the reservation. Using Indian Affairs and the tribal organizations, a multi-agency task force had been convening to exchange information on how to best organize service to address substance abuse. Debates about service models, counseling approaches, and organizational structuring punctuated the discussions. Ongoing public concern regarding inadequate services on the reservation was part of the storefront conversations and political stumping. Highly politicized, the concept of having their own inpatient treatment center formed the background and environment for the Cheyenne River Sioux action plans. The promise of more local services had political merit and public appeal. Those connected to services (program managers, tribal administrators, and clinical staff) held key stakeholder positions on the Healthy Nations advisory committee. The close association with local service augmentation initiatives influenced the original proposal and expectation for the grant monies. This

consortium of professionals continued to inform tribal policy and service philosophy and structure throughout the course of Healthy Nations.

Phase I:

Cheyenne River employed a local group of powerful tribal members, including the tribal attorney, doctoral level mental health and substance abuse administrators, a physician, and the tribal chairman to compose their proposal to the Robert Wood Johnson Foundation. The Phase I proposal was extremely sophisticated. It included research protocol using social indicators developed to highlight the extent and severity of the alcohol problem and ensuing social problems. The proposal, initiated in early 1993, espoused the model of collaboration. It envisioned Healthy Nations as the dynamic organizational liaison bringing together the diverse service programs and agencies. Their theory concluded that more efficient treatment collaboration and greater access to professional services effectively addressed the underlying problems. This public health model exposed the tension between the traditional world view and the more modern medical IHS structure—tension that would impact the development and implementation phases of Healthy Nations. The logo development exemplified this tension. Choosing between a very modern representation of medical and industrial symbols and more ceremonial and cultural symbols, the committee exposed the breaks and weakness in the fabric of community services and theories of change. Finally, they chose the traditional logo, representing ceremonial and historical symbols such as the buffalo and the four feathers

symbolizing wisdom, courage, generosity, and respect as well as the hoop—the classic circle of life. The choice of this logo for the Healthy Nations project was a decisive step foreshadowing a more holistic and traditional perspective in the planning and execution of Healthy Nations objectives.

Upon receipt of notice of grant award, the designated Healthy Nations director, a clinical psychologist, tribal member, and director of the Community Counseling Center, advanced the large Phase I community survey objective. Through a well-organized and structured, research-based assessment process, each of eighteen communities was surveyed twice over eighteen months. Healthy Nations staff and the advisory committee also developed four working task groups addressing (1) alcohol beverage control policy, (2) public awareness, (3) community involvement working partners, and (4) prevention efforts for children and youth. These working groups acted as the advisory committee as Healthy Nations proceeded to respond to the four RWJ grant components.

The first year of Phase I saw considerable effort expended in the development of survey instruments and analysis protocols. The staff also conducted interviews of the community focus groups and stakeholders. These research actions provided a very strong foundation of data which helped to articulate the direction and emphasis of the implementation of Phase II. Year two activities, besides the ongoing community survey, included pilot programs particularly around the use of the media for public awareness and early prevention campaigns as well as the early developments of an alcoholic beverage control policy.

Healthy Nations was placed directly under the tribal chairman in the tribal organization chart. This was significant in that it lent Healthy Nations considerable support and influence within the larger tribal organization. Combined with this strategic political placement was the addition of another highly respected doctorate-level employee who took over the coordination management. These two Healthy Nations personnel represented a significant foundation for forging policy, conducting research, and informing agencies of the direction of the project.

Phase I, however, was not without tension. There were pressures to utilize monies from Healthy Nations to help realize the tribal goal of having an inpatient treatment center as well as augmenting other direct service components. This financial expenditure was explicitly prohibited by Robert Wood Johnson and the NPO. Tribal wishes ran up against the limitations of the grant, and the director and coordinator struggled to negotiate this conflict.

Another contribution to the formative stage of Healthy Nations was the reporting of the data and the infusion of research information generated by the community surveys. This rich survey information and the reported community priorities exposed developing feelings of discomfort and concern from existing agencies, especially around currently used clinical models. Reactions to the exposure included withdrawal from participation in collaborations, rigid application of professional status, and divisive politicizing of concerns. Adding to this growing divisive context was the change of tribal chairmanship. Healthy Nations was slipping in political stature and losing vital intra-tribal support. This

early tension played out through the remaining five years into Phase II of Cheyenne River Sioux Reservation Healthy Nations.

Transition:

Preparation of the objectives and goals for Phase II implementation began in the second year of Phase I. With preliminary data and understanding communities' needs and wants, the staff identified youth activities and interventions as primary. Secondary and equally weighted was the community belief that stricter laws and punishment were very effective and central tools to prevention. This legalistic perspective shadowed community prevention and public awareness activities throughout Healthy Nations. Such foci set the stage for implementation in Phase II.

Transition into Phase II carried significant wounds and challenges to the ideals of the original grant. The most devastating challenge came in staff turnover. At this vulnerable time, both the original director and the coordinator took new positions away from tribal service. The attorney, one of the stronger proponents, also left the reservation. The advisory committee and the task groups deteriorated; the new tribal chairman also shifted interest, and the other providers withdrew any remaining support. This left a six-month hiatus without leadership or direction.

The realization that the Cheyenne River Sioux Healthy Nations was drifting and directionless prompted a technical support visit from the NPO. Representatives of the national office and tribe engaged in a series of intra-tribal

negotiations, hoping to right the ship and reestablish favorable connections and direction for the program. The Phase II proposal was still without approval.

The NPO had concerns that public awareness was not getting adequate attention and that attempts to use grant money for direct services continued as well as concerns about growing disaffection between established tribal departments and the program. Healthy Nations was no longer housed under the Tribal Health Department but placed under the Tribal Treasury Department, a more off-site location. The reason given was the complexity of the financial arrangements with RWJ.

Now six months into Phase II, a new proposal was produced. The theme of Phase II was Wolakota Yukini (to make live again, culture, tradition and language). The tribe hired a tribal member as director. He was less professionally qualified through academia but was more traditional. He was not as connected in the tribal governmental relationships as the previous director, but he had stronger cultural grounding and language skills. This shift in status, support, and leadership complicated reaching the objectives developed in Phase I. Healthy Nations became more isolated.

Phase II:

Early in the second year of Phase II, Cheyenne River Sioux Healthy Nations created a Lakota youth camp program. This 74-day-long summer camp targeted at-risk youth. Organizers used traditional activities such as horseback rides along the Cheyenne River on ancestral trails as healing medicine. The

connection of tribal volunteers to these youth, while teaching traditional values and alternatives to current behaviors, served to revitalize the culture and increase participants' esteem. The camp model included a social rehabilitation and criminal diversion philosophy which established a connection between Healthy Nations and juvenile justice. This camp received tremendous attention, both nationally and within the state. A *Time* magazine article praised the camp as a diversion process in juvenile justice working with delinquent youth. This exposure branded Healthy Nations with a misguided connection to juvenile justice, and this reputation confused the goals of using tradition to influence youth and families through Healthy Nations.

This camp experience deepened the rift between the established clinical service providers and Healthy Nations. Some tribal organization accused the camp staff of unauthorized counseling following a poignant encounter with a participant. Compounding the tension over professional scope of practice was the flexibility of Healthy Nations funding. The inherent struggle for control of scarce resources and the long-standing need for expanded direct services further alienated the Healthy Nations program from the central tribal providers. Public exposure and a positive multiple-page article on the horse camp in *Newsweek* brought recognition to this new program. Some divisive attitudes and distancing behaviors from other providers intensified.

The National Program Officer noted what was perceived as heavy staffing and limited direct objective fulfillment, prompting another site visit in year two. Negotiations and discussion about meeting the proposal obligations focused on

the outreach staff. Noting the reality that Healthy Nations covers 2.8 million acres and eighteen communities, the director argued that outreach personnel were needed. Complicating matters was inadequate funding to keep these people on staff full time and so personnel changes made it difficult to fulfill all of the directives. The director also shifted the vision of Healthy Nations from the public service model of Phase I to a model that used traditional activities as preventive and curative. This shift was not anticipated by the NPO and was not reflected in the Phase II proposal. The site visit left many concerns unresolved but accomplished mutual understanding of the political environment, personnel situation, and changing philosophy of the program.

Highlights:

The increased focus on tradition and culture was successful. The preventive and curative medicine of cultural respect, accountability, and responsibility was interwoven into all activities. An example of this infusion is the horse programs. Healthy Nations developed an adopt-a-horse program and summer horse treks along the Cheyenne River bottoms (traditional sites) to engender traditional and pro-social values in youth. This type program stretched the flexibility of the NPO and for Robert Wood Johnson. Spirited discussion and communication with Healthy Nations to support the purchase of horses and feed ensued. The director and the horse program coordinator responded by convincing individuals in the community to donate horses from their ranches. Working with these horses taught kids about responsibility as well as exposed

them to the nightly traditional and culture activities associated with the camps. This adopt-a-horse program and riding camps effectively touched tough gang-want-to-be kids and delinquents. It allowed these youth to find gentleness and identity in the ways of their fathers. This program thrived for two years until a bad winter killed many of the horses. Concurrently, the coordinator moved on to another job. These two events led to the demise of this popular program.

A year later, understanding the cultural significance of using horses as a reflection of Lakota ways, Healthy Nations developed an after-school riding program. Again local ranchers and members of the community rallied to donate horses. Responsibility, respect, and sharing were principles taught at this activity. No use of substances or behavioral disruptions was allowed. The kids would present a slip of accomplishment and accountability from school. These two requirements, no substance use and positive school involvement, qualified participants to ride the horses. After-school horse riding was so popular that the program had to set an every-other day, gender-specific schedule. The staff also had to limit riding time. Even today, youth and parents call to ask if the horse riding program is available.

The director and coordinator utilized this program as a method to teach the history of the Lakota people. Proper roles and social respect were taught based upon the use of the horse, the symbolism and ceremony around riding, the status of the warrior, and the wisdom of the women. This was part of an overall revitalization of culture and theory of change using tradition and ceremony as

protective factors. Healthy alternatives, combined with increasing cultural pride and identification, addressed the objective of prevention and early intervention.

Healthy Nations recognized that the Elders were alienated from the youth. The director also believed that the program should support the carriers of tradition and ceremony. A program, named “Keepers of Wisdom,” was subsequently initiated, providing occasion for Elders to congregate and share with each other. As this Elders program thrived, Healthy Nations introduced at-risk and aftercare youth into the gatherings. It facilitated trans-generational appreciation and relationship, stimulating an “adopt a grandchild/grandparent” interaction. Bridging the generations helped reconstruct the collective community of times past. These Elder/youth gatherings continued through the last days of the Healthy Nations program. Instrumental to the future and prevention efforts, the combination of tradition, relationship, and sober alternatives formed a foundation of community change.

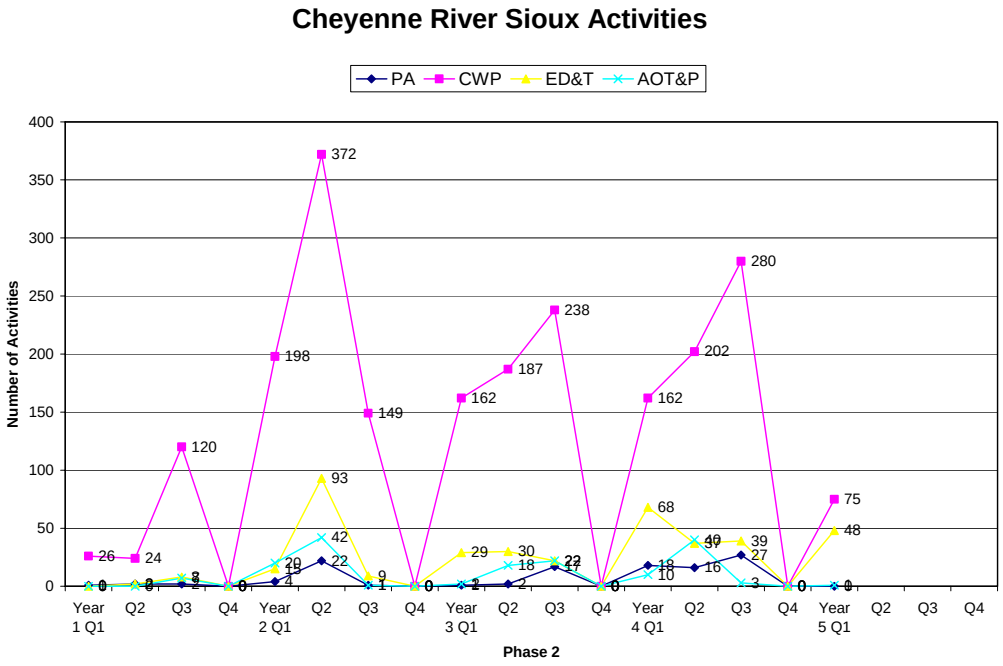
These successes are balanced by struggles and failures. Throughout the years of Healthy Nations, problems with accurate reporting, honest reflection of the state of affairs, and utilization of funding remained. Complaints that the leadership lacked sufficient energy and enthusiasm for the objectives were leveled from both within and outside the tribe. Differences in philosophy and style plagued political relationships. Resource allocations and reporting requirement deviations frustrated the NPO and consumed much of the director’s energy. Programs started and withered without bearing fruit. Staff quit or took other jobs. Various objectives remained unaddressed, and the goal of coordination and

collaboration waned into dissent and indifference. A divide between professional models and community outreach and empowerment defined most of the course. The evolution of the program was uneven, punctuated and slow; but it did produce some results with lasting effects.

The six-month no-cost extension finally saw a reprieve from the tensions present since the end of Phase I. Other service providers finally came to realize that the Healthy Nations Initiative was not a threat and that the data and funding flexibility were beneficial. The camps, cultural programs, horse riding, and activities reconnecting youth and Elders formed effective and complementary early interventions and aftercare components. This end chapter saw a greater collaboration and connection between the tribal treatment sector and Healthy Nations. Sadly, this was too late for both the trajectory and the intensity of Healthy Nations and the other associated substance abuse programs. Changes in the political landscape finally provided greater inclusion of the programs espoused in Phase II. Healthy Nations started to thrive through this long maturation and proving years only to disappear as funding runs out.

Today, the legacy of Healthy Nations is continued in the cultural preservation programs. Building on program ideas and experiences with “Keepers of Wisdom,” the tribe is involved in recording the stories and revitalizing the traditional knowledge of tribal members. Legal barriers to rampant alcohol consumption on the reservation were positively impacted by the Healthy Nations data collected in Phase I. Personnel who were involved with Healthy Nations maintain the philosophy and hopes of the program. Other agency managers and

coordinators learned of the power of community involvement and the trusting of traditions and ceremony in healing. Healthy Nations acted as a catalyst for understanding natural tensions among agencies and problems with coordination. The logo chosen early on depicts the cycle of life and the four principles of wisdom, courage, generosity, and respect. Healthy Nations evolved to represent and epitomize that logo.



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Confederated Salish and Kootenai Tribes

The Flathead Reservation: St. Ignatius, Montana

Healthy Nations Program

December 1993 – September 2000

“A Path from Linking Services to Connecting Generations and Beliefs”

The Confederated Salish and Kootenai Tribes Narrative

Historical Context:

The Confederated Salish and Kootenai Tribes of the Flathead Nation is a Healthy Nation program established in Western Montana. The Flathead Indian Reservation comprises 1.5 million acres of reservation land that was established by the Hellgate Treaty of 1855. It is bounded on the east by the Mission Mountains, on the west by Rolling Plateaus, and on the north by the largest freshwater lake west of the Mississippi, Flathead Lake. The reservation encompassed eight communities: Arlee, Charlo, Dixon, Elmo, Hot Springs, Polson, Ronan, and St. Ignatius. Ronan is home to the Tribal government and center of most tribal services for the reservation except for St. Ignatius which is home to the health department and tribal health services. The tribal government consists of an executive secretary and ten elected council members. Governmental services and oversight are divided into departments directed by program managers.

The economy of the reservation is based on timber, tourism, and agriculture. The land supports traditional uses, spiritual grounding, and economic viability for the tribes. The Flathead Indian Reservation is somewhat unique among all American Indian Reservations. In 1910, under President Taft, non-Native individuals were allowed to homestead on reservation lands. This historical event set in motion many relationships, barriers, and wounds that contributed to the atmosphere of Flathead Reservation life. As of 1990, the

Indian population was a significant minority, less than 20 percent. The reservation is home to approximately 22,000 people with only 5,130 of them identified as Native Americans and even fewer are enrolled Salish and Kootenai members. This rural reservation and its people are commonly known as Flathead. In reality, three tribes make up the Native residents: the Salish, the Pend-d'Oreilles (Kalispells enrolled as Salish), and the Kootenai (people of the Standing Arrow). Only one-half of the registered tribal members reside on the reservation; roughly 4,200 tribal members live elsewhere.

Like most Native American communities, the Salish and Kootenai Tribes have experienced a disproportionate negative impact caused by drugs and alcohol abuse. The tribes have witnessed personal destruction, cultural erosion, and the ensuing social disruption associated with significant substance use. It is reported that 70 percent of the tribal members abuse alcohol or other drugs. A state survey found that Flathead reservation suffered the highest mortality rate in Montana—a majority associated to substance misuse. In 1984 a youth survey determined that 21 percent of Flathead youth met the criteria for substance dependence. A later survey of seventh through twelfth graders revealed that 90 percent of those surveyed had used alcohol and 54 percent had used marijuana. A 1991 reservation survey indicated that 90 percent of respondents knew someone that needed services for alcohol- and drug-related problems. The Flathead tribal council and service providers had long been aware of and had been actively addressing alcohol and its related problems. It was the vision of tribal leadership, the re-awakening of cultural traditions around extended family,

and community-based data that prompted the tribal council to demonstrate resolve and allocate more resources to addressing substance abuse. The Flathead Reservation Area Comprehensive Alcohol Program, a detoxification service, had been noted in the late 70s and early 80s as “a model IHS program.” Boldly, in1984, the tribal council undertook a revamping of their reservation drug and alcohol programs, an action which led to an expanded continuum of care, including integrated community-based prevention. This revamping demonstrated forethought, courage, and meaningful innovation.

The expansion and repositioning of the alcohol- and substance-abuse programs guided the tribal council to establish the Omnibus Drug Act. This decree demanded that the Tribal War Dances (Powwows) and all tribal government activities and facilities be drug free and was followed, in 1987, by a distinct tribal action plan targeting substance abuse. This action plan stimulated the development of the Blue Bay Healing Center on the shores of Flathead Lake. It was here that all tribal government officers, directors, and select tribal members were educated about drug-free workplaces and dealing with substance abuse in the community. It was a place of sober gathering and healing. Blue Bay was that inaugural function of the tribe’s new Alcohol and Substance Abuse Program (ASAP).

In 1990, as ASAP matured, the action plan became central to the tribal management philosophy. The increased focus on individuals and families affected by substance abuse on the reservation created the foundation for Healthy Nations. The Center for Substance Abuse Prevention (CSAP) funded a

proposal titled “Beyond Blue Bay Project.” Primarily a program to enhance the continuum of care on the reservation, this project conducted the aforementioned survey of middle- and high-school students to see the impact of drugs and alcohol on their families within the reservation. The data confirmed the common knowledge that a majority of families had substance-related issues. The survey results also indicated that having access to resources and treatment information was lacking. At that time, numerous non-Native agencies were joining the ranks of reservation providers. Contract services within the tribal constellation of mental health and substance abuse as well as primary care grew but lacked central coordination and single access. Combined with the Beyond Blue Bay data, this diffusion of services posed a perceived challenge to addressing substance-related issues on Flathead reservation.

Phase I:

It was the ASAP director and an Indian Child Welfare Act prevention specialist that noted the advertisement for the RWJ Healthy Nations call for proposals. They participated in the pre-grantee meeting and decided that this initiative was something that could enhance their ASAP program. To prepare the proposal, they sent out 75 fliers to provider agencies, Native and non-Native, in their catchment area. Twenty-nine agencies responded and sent representatives, mostly managers, to attend “DREAM,” the first grant advisory meeting. These agency directors represented social work, addiction services, juvenile justice, the schools, doctors, community health nurses, and day care providers. This body

decided that they would compose and submit a proposal for the Healthy Nations grant. The grant proposal philosophy posited greater collaboration and coordination among the service agencies. It outlined that facilitating service seekers in acquiring appropriate information and referral was primary to addressing substance abuse on the reservation. This vision of Healthy Nations as the central intermediary of better-coordinated services and referral information informed the grant proposal, planning, and development phases as well as much of the implementation phase.

"Netlink," as the program was known, conceived a help line resource management program as the central component of Healthy Nations. The help line was to connect all services providers, maintain a referral system, and provide salient clinical consumer information. This was especially important, given the vast territory and pattern of population dispersal. Adding support to a philosophy of linking providers and services grew from the recognition that many, if not most, services available were off-reservation and not administered by the tribal programs.

During Phase I, efforts focused on procuring appropriate computer software, establishing relationships between each agency that worked with substance-abusing tribal members, and raising public awareness of the service. Netlink's director and staff were committed to the concept, and the advisory committee held numerous meetings. Media focus groups were conducted in six of the nine communities, eventually leading to the development of three products, one of which was a poster for Netlink.

Public awareness also included a 30-second television spot on alcohol abuse problems produced by fifteen youth. This promoted the Netlink concept and furthered the development of the 1-800 referral line to cover the two or three phone districts across the catchment area. Healthy Nations staff conducted personal visits to different agencies to gather service-related information for distribution through Netlink. Public awareness focused on introducing Netlink and the Healthy Nations name. Concerted activity was expended to solidify the networking philosophy. This dedication to this central function of coordinating associated agencies is noteworthy.

As Phase I reached conclusion, there were growing concerns at the National Program Office (NPO) that Flathead needed to have a more balanced stance in addressing the RWJ Healthy Nations components. There was also concern about the documentation processes and reporting of activities. Such concerns added to the stress of the director and defined the transition process.

Transition:

Transition into the Phase II implementation grant component was extremely stressful and nearly resulted in removal of this site from Phase II consideration. There was concern about the direction and management of the program. The Netlink director experienced distracting struggles during this crucial time; the task of coordinating the Netlink web of providers and the monitoring of the referral line was consuming a majority of resources and almost total focus. The Phase II implementation proposal continued to support this feature almost

exclusively. A timely NPO site visit attempted to redirect leadership, provide technical support to expand the Netlink scope to the other RWJ components, and facilitate a more responsive documentation procedure and policy.

This meeting was a prelude to and an outlining of the important Phase II implementation proposal process. This proposal process needed to reflect lessons learned from the previous two years in how to address the four RWJ components. From May 1995 through January 1996, Salish Kootenai presented the NPO and the NAC with four iterations of their Phase II proposal. In the fall of 1995, after the third proposal was rejected, a meeting at Flathead with the NPO, staff, and tribal leaders convened. At that time a Healthy Nations Netlink management change took place. The initial director moved to a different job and an existing Netlink staff member was assigned the directorship. This action was prompted by the NPO's ongoing concern that each proposal effort did not adequately address the early intervention and treatment and aftercare components. The emphasis on the Netlink was too singular in focus for the targeted outcomes from Robert Wood Johnson. Technical support from the NPO was provided in the rewrite of the fourth iteration. The Netlink representative was taken to Denver to finalize the proposal. The final proposal was presented in December of 1995 and was subsequently approved as adequate but did not meet all of the NPO's expectations.

Phase II:

Consistent with the Netlink director's vision and commitment, Flathead Healthy Nations continued to utilize the original community agency advisory board and emphasized the resource networking. Grant resources were used to compile information regarding specific treatments, available providers, and consumer-friendly topics relevant to health and recovery. These were distributed through Netlink. There was an increase in public awareness and prevention activities, especially participation in school-based presentations and youth gatherings. Netlink generated curriculum and classroom interventions to be distributed around reservation schools. They sponsored a Youth Conference and created public awareness PSAs and outreach materials. Healthy Nations expanded its scope by including more work with other established community agencies in sobriety activities, traditional education programs, and resource support for community events.

In year two of Phase II, there was a reconstruction of the service delivery model on the Salish and Kootenai Reservation. The tribal council and health services division revamped departments creating the Tribal Health and Human Services division. A subdivision of the Tribal Health and Human Services, the Community Health Division, became the organizational home to the Healthy Nations Netlink program. This change strengthened administrative oversight, a concern voiced by the NPO during the rewriting of Phase II proposals. This administrative placement increased compliance with the complex financial

reporting. This shift in management responsibilities increased intra-tribal service connections and communication.

Concurrent with these tribal changes, the NPO convened a site visit to shift the focus of the grant resources. The growing concerns about the Netlink resource line culminated in NPO and NAC frustration and strong action. Evidence regarding the inappropriateness of continuing the current direction was based on data that showed significantly fewer-than-expected calls to the 1-800 referral number. Further undermining the Netlink system was the question of the advisory board's continuing value. Reassessment of its viability developed from its ineffectual functioning, including many meetings without quorum or worse—no attendance. This weakening of a working steering group and agency network undermined the central tenet of the original Healthy Nations proposal and concept. The vitality and viability of the Netlink was under serious scrutiny. Tribal leadership, Healthy Nations staff, and the visiting NPO and NAC members met to resolve this situation. Again, the stakes were high, prompting a radical overhaul and repositioning of the Healthy Nations program. The Tribal Health and Human Services administration proposed a solution by shifting the Netlink management oversight to the Mental Health and Addictions Treatment Services. They restructured the leadership of Healthy Nations, adding the Netlink/Flathead Healthy Nations Program to the roster of projects under the existing director of the Mental Health and Addictions Treatment Services. This new Healthy Nations director moved quickly to integrate the existing Netlink staff. This adjustment was

challenging but proved wise and rewarding. Personnel remained stable throughout the following two years of the program.

The new director's attempt to rewrite the objectives and goals was resisted initially by the NPO. Their demand was that Flathead fulfill the Phase II objectives as stated. The director had cited the demise of the advisory steering committee and the underutilization of "Netlink" as reasons for the revision. She proposed shifting to a participatory model of prevention through partnering with established community resources. Substituting existing community committees and traditional groups as the guiding voices was the first task of the new administration. The goals were now to reflect the desires and opinions of these nonprofessional committees. The advisory group was no longer program and agency driven, but rather directed by Elders, cultural committees, and youth groups. Traditional relationships and respect guided the energies of the last two years. Traditional Salish and Kootenai belief is that you must act if you consult the wisdom of the Elders and community for guidance and direction. The new Healthy Nations programming challenges were to honor this tradition and, simultaneously, to fulfill the Phase II approved objectives. Better documentation and reporting, changes at the NPO, and increasing success in the community created a more flexible interpretation of grant-objective completion.

A second challenge was steering the staff of the Netlink to new directions. They were loyal to their vision of networking all of the agencies as the answer to the problems of substance abuse. The new director spent a lot of time educating both her staff and the NPO about the benefits of listening to the existing

community organizations. The conversion process was instituted by assigning the Netlink staff to attend and participate in each of these community meetings. They were sent to listen to the community's concerns regarding children and youth affected by substance abuse, including tobacco. Most worries and ideas that arose from the Elders and culture committees concerned smoking, the loss of traditional respect, and the decreased understanding of the spiritual identity of being Native. The wisdom of the community prompted a greater focus on smoking cessation.

The director set about to re-tool "Netlink," as well as the community partnering activities. The new emphasis would be on becoming a technology and information transfer resource and would include providing curricula for schools and prevention and clinical information to all consumer groups. The new director also desired to forge stronger intra-tribal program relationships and a more circumscribed focus on tribal members. Such attitudes and program development infused with more traditional wisdom and cultural aspects became the solutions to the substance abuse problems.

The emergence of these broader traditional relationships and activities demanded greater flexibility in resource management, the surrender of the concept of expert authority, and the expansion of how certain activities addressed the RWJ components. Healthy Nations transformed from a program and project to a vital partner with communities and services fighting the devastation of substance abuse and erosion of tradition and culture.

Highlights:

In responding to the community voice, Healthy Nations helped to bring about a tribal ordinance restricting smoking by all persons under the age of 18. Such an institutional product remains in effect and demonstrates the commitment of the tribe to substance abuse issues. A similar tact was taken to address fetal alcohol syndrome. The Elders and cultural representatives, in association with the Netlink staff, pronounced a historical prohibition regarding female substance use. Building on the success of the anti-smoking ordinance, the Netlink staff proposed limiting the consumption of alcohol by pregnant women. This proposal met with legalistic barriers and eventually died without action. Although it failed to reach tribal ordinance level, the proposal did increase discussion about the use of substances by women while pregnant. Public awareness and tradition teaching were accomplished; community consciousness was raised.

Locally held theories about the etiology of substance abuse included a loss of cultural identity and ceremonial living. Healthy Nations and the community committees understood the central role of culture. The connection of culture and behavior as well as the strength of Healthy Nations philosophy of joining is highlighted in the following vignette.

A tribal member was found to have wasted animals during a wanton hunting spree killing more elk than permitted and needed for his family. This upset the Elders. During a committee meeting, the idea of teaching the new generation of youth the traditional uses and respect for the animals was discussed. The group suggested to the Healthy Nations representatives the need

to address this loss of respect and knowledge. True to the new philosophy of responding to the voice of the community, Healthy Nations flexed beyond the usual practice and explicit grant objectives. Funding for community members to go hunting, purchase ammunition, and negotiate with the Fish and Wildlife department appeared outside the grant's intent. This was a challenging event designed to be substance and tobacco free. This activity bridged a gap between Elders, adults, and youth. It provided a traditional education and sense of respect and increased consciousness in both youth and adults about sacred rites like hunting. Participating youth were provided a traditional reverence toward the hunt and animals and were given an alternative to the usual modern hunting practices and values. The experience also sent a message about healthy and traditional living and was an unprecedented success for all involved.

The camp became an annual event encompassing more cultural components and lessons. This traditional hunting camp has been perpetuated through coordination with the Department of Fish and Game of Montana which had participated in the first camp. Scores of young people and tribal adults spend quality time in the ceremony of hunting and enjoying sober recreation. Respect has grown; pride has increased; and traditions have been revitalized.

Healthy Nations "Netlink," capitalizing on previous interagency connections, established a mechanism by which minors in possession could give back to their community as a way of understanding cultural relationships. This tribal diversion program obligated the youth to work with Elders, perform community services, and remain in the community. A sense of responsibility and

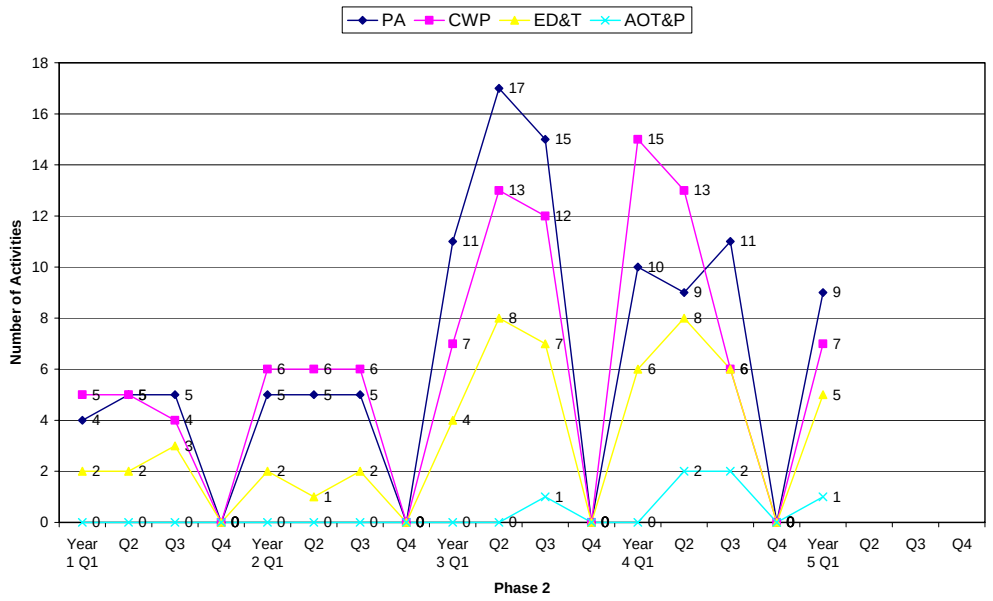
collective identity replaced individual punishment and minimal restitution. This program continues under the drug elimination program sponsored by HUD in coordination with tribal and state agencies. Punishment for many youth was transformed into a restoration of harm done and reconnection with community.

One positive intervention grew from opportunities afforded directly to Healthy Nations staff. The staff traveled to a conference on criminal thinking and the corrective process. This training struck a cord as an avenue to influence destructive patterns of thinking prevalent in the general community at Flathead. The concept and principles were presented to the Elders and the cultural councils. Excitement and encouragement about this program generated a community conference on corrective thinking. The program was established as a mechanism to teach parents and providers about guiding the youth. Some 70 individuals attended this tribal training. The principles and techniques taught in this conference continue to inform tribal programming and interventions.

The Salish and Kootenai had three lives of Healthy Nations. Over the course of these lives, efforts were made to bridge interagency differences and philosophies. Although the last director laments that there was some loss of opportunity during the evolution and readjustment of the program, she lauds the dedication and flexibility that grew through the program maturation. Processes to allow the consumers greater access to information were attempted. Although this referral mechanism was never fully utilized as envisioned, it provided dialogue, partnership, and opportunity for the different agencies to reach out to the community. The philosophy of being able to listen to the community, especially

the existing committees and natural leaders and to respond to them was institutionalized through the Healthy Nations program. This model is demonstrated now in a greater continuum of services and broader specialty components being provided by the tribal organization. Healthy Nations reminded the community of their inner strength and deep wisdom. This project established greater attention to the power of the Salish Kootenai collective traditions and their preventive and healing powers.

Salish Kootenai Activities



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CWP = community-wide prevention
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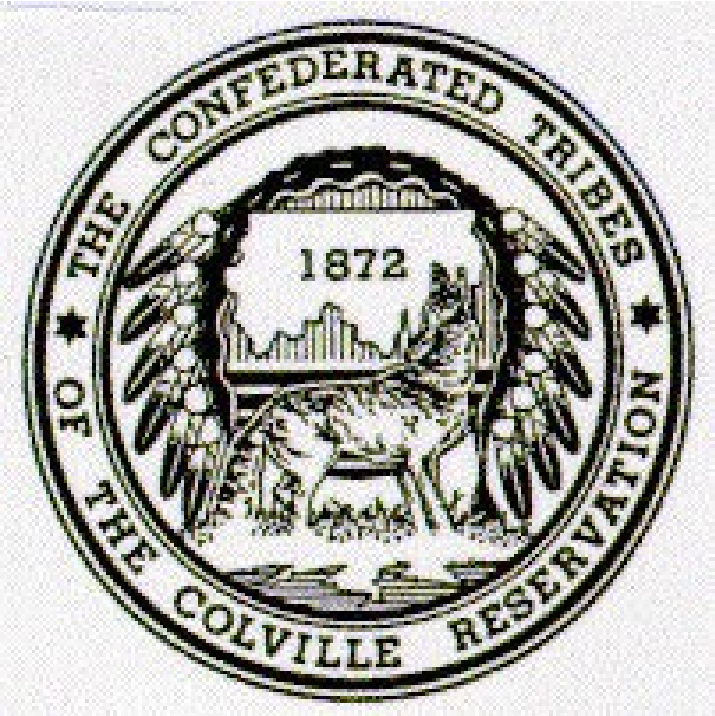
Confederated Tribes of Colville Reservation

Nespleum, Oregon



Healthy Nations Program

December 1993 – July 2000

“Reclamation of Heritage and Youth Identity in a Multiple Tribe Reservation”

Colville Confederate Tribes Narrative

Historical Context:

The Confederated Tribes of Colville consists of twelve bands of different peoples that historically ranged from the Cascades to the Rocky Mountains and the Canadian Border to the Mississippi River Valley. Set aside in 1872 under Executive Order by President Grant, the current reservation covers 1.3 million acres in north central Washington State.

The twelve tribes include Okanogan, Lakes, Colville, San Poil, Nespelem, Methow, Entiat, Chelan, Wenatchee, Moses-Columbia, Palouse, and Nez Pierce. These bands were settled within the Colville Indian Reservation. The reservation is divided into four political districts and towns: Nespelem, Keller, Inchelium, and Omak. Many of the total 7,800 tribal enrollees live off the reservation in nearby communities, and approximately 5,000 tribal members are living directly on the reservation.

The constitutional government is known as the Colville Business Council. The fourteen-member council is elected to office by vote from the four political districts. Elections are held every two years; this political cycle presents frequent changes in tribal direction and governmental affairs. The Colville Business Council is responsible for the economic, social, and judicial programs servicing its members. The major administrative departmental subdivisions include Human Services, Management and Budget, Natural Resources, and Tribal Government.

The Healthy Nations “A Way of Life” was located in the Human Services division. Oversight responsibility resided within the Tribal Community Counseling Services.

Alcohol problems have been apparent for many years on the reservations. Information outlining the extent of alcohol and substance abuse are suggested, although the proposal lacked many specific citations. A commonly held belief was that the problem exists and was considerably greater on the reservation than in surrounding areas. One cited source, the Omak School District study (1992), substantiated this belief. The data of matched student populations across Washington State and the Omak schools revealed that reservation students used more drugs and alcohol. The study also indicated that the American Indian students endorsed a greater rate of moderate to high use than their matched peers. Reported tribal substance abuse encounters would support the premise of dramatic alcohol-related problems on the reservation. In 1992, over 1,400 substance-abuse-related outpatient visits were registered. Further indicators of substance abuse and related problems are reflected in the actions of the Colville Business Council over the past decade. Following the Tribal Action Plan of 1986 and 1988, the tribe constructed a thirty-six bed residential treatment facility, expanded community counseling services, and promoted more drug-free alternative activities for youth. The Council, between 1986 and 1991, also passed resolutions directed at alcohol and substance abuse including the Substance Abuse Policy for Tribal Employees, the Children’s Proclamation, and an ordinance prohibiting substance use on tribal property. Notwithstanding the

preponderance of indicators, strong denial of the problem still exists. Many in the community and in leadership positions simply dismiss the data and indicators.

Unemployment of tribal members was high although the area was rich with natural resources such as lumber, wildlife, and tourist attractions. The standard of living remained lower compared to the state of Washington and was more accentuated between north central Washington and the reservation. Other social indicators demonstrated the disparity between reservation life and the surrounding communities, including morbidity and mortality statistics, educational status, and criminal involvement.

Phase I:

The Business Council formed what is called the “Eight Core Committee.” This committee consisted of managers, directors, administrators, and associated representatives of tribal services and organizations. They were charged with investigating the call for proposals received from Robert Wood Johnson. The human resources staff then attended the pre-grantee meeting, and with excitement and the intent to enhance the residential program, they endorsed submitting a grant. The core committee worked together, composing a proposal targeting expansion of community services, especially the direct service components. The proposal cited the development of a congruent “Healthy Nations” program of traditional healing and western treatment. The Committee entitled their project “A Way of Life,” a name which referred to the historical meaning of “medicine.” Medicine—the power of community, language, culture,

family, nation, and the environment—was the program's prescription for change. Following a positive pre-selection site visit, Colville became one of the fifteen original grantee sites. According to reports, they felt extremely privileged to have been selected for the planning and development Phase I grant.

Seeking to enhance previous tribal efforts addressing substance abuse, the program, "A Way of Life," began networking among tribal and non-Native agencies and initiating a community outreach effort. Instituting a holistic management method through "visioning" meetings, key stakeholder interviews, and community surveys, Healthy Nations focused on increasing the voice and empowerment of each community. This method guided the development of programs believed by the communities to be effective.

Healthy Nations was quite successful in surveying over 500 people in the four communities. Representatives of the youth, elders, and family members suggested a number of activities to prevent abuse as well as articulated their visions of how the community would be if there was no alcohol or drug abuse. These meetings elicited ideas about what would help to develop and sustain a healthy community. Using previous research, tribal wisdom, and professional understanding of the dimensions of the problem, the committee and the Healthy Nations director continued to propose objectives and events that arose from community dialogue. These ideas and plans were found to be somewhat at odds with prevailing prevention and treatment ideas. The well-established models and clinical perspectives embraced by other agencies and granting sources created barriers and challenges to the emerging community-based Healthy Nations

philosophy. The existing and accepted practice of dictating to the community what they were going to do clashed with the community partnership foundation of Healthy Nations.

This was the period when initial tension arose among tribal government, selected tribal service agencies and personnel, and Healthy Nations, especially regarding direct services provisions. The limits of the grant did not permit use of funds for direct services, but the tribal council and others believed that the grant money should be used for expanding the treatment sector. The director was caught between two responsibilities—Healthy Nations expended energies and resources forging and maintaining a clear identity and an apolitical stance. This early political uncertainty and tension would influence the effectiveness and dimensions of Healthy Nations throughout the granting cycle.

Being part of a Robert Wood Johnson Foundation grant provided visibility, status, and associated power. The Healthy Nations program was leveraged for reasons of political and social change, resulting in the Healthy Nations name and association with the program being used outside the context of the grant. As was common with other tribes, Colville was seeking to increase their continuum of care and was anxious to expand the number of inpatient beds under their tribal Community Counseling Services. Thus began a persistent dialogue between Healthy Nations directors and the tribal government about the allocation of the grant resources, a situation which eventually necessitated a site visit and other interventions by the National Program Office.

During this early formative period, Healthy Nations leadership was a secondary function of the director of an associated tribal program. The scope and breadth of the grant requirements as well as attending to each of the four communities necessitated a managerial structure change. A new director, assigned the responsibility for Healthy Nations, had been associated with the early program administration of grant compliance and fiscal matters. Possessing a strong personality and good community and tribal identity, she would be the only Healthy Nations administrator notwithstanding a period of interruption. This stability provided the needed strength and commitment to maintain the energy and support for the evolution of the Colville Healthy Nations program.

During Phase I, Colville focused most of their energies in working with their youth. Efforts to sponsor clean, sober, and safe activities for youth and their families were the highest priority. The community survey indicated the need to connect youth and families to traditional and ceremonial spirituality emphasizing a cultural understanding about the complex nature of their relationship—one to another and to the land.

Outlining what the goals and objectives were going to be throughout the next six years occupied the Healthy Nations staff. One method used to clarify the program direction was to create vision and mission statements. Originally, the Phase I program had a very long mission statement, felt to be too comprehensive and complex. The director thought it was important for the mission statement to be understandable to the general public. During an eight-hour session, the staff of Healthy Nations and associated tribal staff met and drafted a very succinct and

positive mission statement highlighting the principles of respect, acceptance, and healthy choices in all activities.

The staff employed the same methods in focusing the myriad of ideas and suggestions they had received from the communities and agencies. Posting the requests and suggested activities on the wall of the office, the staff grouped, re-grouped, and combined ideas into a workable list of events and activities. Finding common themes and identifying community resources and partners, Healthy Nations developed a reputation for action and responsiveness. This process also facilitated the assignment of the activities into the appropriate RWJ grant components.

During Phase I, Healthy Nations worked with the tribal council to pass ordinances to support sober lifestyles. Unfortunately, it became distorted through miscommunication and political opportunity by connecting Healthy Nations with advocacy for going to a dry reservation status, which did little to encourage community support and, in fact, precipitated concern and many negative phone calls. Colville Healthy Nations would struggle to repair that situation throughout the grant period, all the while trying to gain greater understanding of community desires. This unfortunate association with legislating sobriety through loss of choice ran counter to the belief and stance of the program. The philosophy of the Healthy Nations staff and the direction of “A Way of Life” was that inner strength, not external forces, was most important and powerful in the fight against substance abuse. The program staff eventually turned the negative perception around to a positive one by using the opportunity to engage in conversations

about alcohol and other substances with those making contact. This situation also propelled the Healthy Nations name into dialogue about substance abuse.

Transition:

Community outreach had produced a diverse compilation of suggestions and opportunities. The staff placed all of these suggestions in categories based upon the four components of the Healthy Nations grant. Many survey respondents had indicated that they had limited or no access to bringing information or concerns to the tribal government, and the staff created a fifth component for facilitating consumer access to the tribal council. This exercise of categorizing and sifting the suggestions and community wishes aided the staff in articulating the Phase II objectives and activities. The set of objectives addressing public awareness, prevention, early intervention, treatment and aftercare issues as well as a fifth goal and objective—becoming an avenue or liaison between the government and community members—became the core components of the Phase II proposal.

The transition period experienced challenges when the Healthy Nations director was unexpectedly moved into a different position within the tribal department of education. This left “A Way of Life” temporarily without leadership. With the process of writing the Phase II proposal underway at that time, this leadership change left the program coordinator with the responsibility for the grant proposal. After submitting four iterations of the proposal, each of which was rejected by the National Program Office, a site visit was conducted. The

intervention from the NPO with the tribal government and the Healthy Nations coordinator resulted in reinstating the former director. She was once again put in charge of the Colville Healthy Nations, now to be located in the tribal education department. This move from the health department to the education department provided a more parallel philosophical fit and further allowed for greater management oversight. The relocation also benefited the program with an increase in staffing. Phase I efforts and struggles revealed that two full-time staff members were insufficient for the scope and intensity of the community and grant demands. Following this period of confusion and challenge, and along with the NPO intervention, the tribe authorized in-kind support by funding four activity coordinators, one in each community.

Phase II:

Many positive insights were gained as Healthy Nations applied the survey data and implemented the community suggestions. The diversity of the Colville Reservation, the lack of healthy alternative activities, and the loss of identity, all contributed to the behavioral problems exhibited by the youth. Many of the young people had formed gangs or were loosely associated with gang-like activities. Substance abuse, alcohol use, and a growing incidence of violence followed this trend.

While conducting surveys and activities, the Healthy Nations staff discovered that most of these youth were unaware of their tribal and family relationships to opposing gang or group members. During some of the Healthy

Nations-sponsored youth gatherings, the youth were asked to introduce themselves. Initially, they would give only their first names with little else; staff thought this was resistance or, simply, a reluctance to share. However, what the staff had uncovered was a more insidious problem—the youth did not know who they were. With help from the Elders, the staff sought to teach them to identify themselves through their genealogy and tribal affiliation. Each youth was charged with returning home and inquiring about their tribal affiliation and the names of grandparents and great-grandparents. This exercise revealed that would-be rivals were actually related; and the discovery of being family, reportedly, diminished allegiance to the gangs, broke through the sense of isolation, and exposed the strength of cultural roots. This revelation strengthened tribal associations as well as helped to alleviate the intra-community antagonism. Cultural identity, tradition, and relationships became preventive and healing medicine for those youth and, by association, for the community.

The focus and efforts of Healthy Nations shifted early during Phase II. The growing list of planned activities inspired the program to look to a co-sponsorship model. Driven by the nature of volunteerism, time demands, and the geography of the reservation, it became more favorable to participate with other organizations and in other, already well-established events. Healthy Nations began redefining the application of their mission through increased collaboration and offering support to other projects with similar intentions. The resistance to duplicate efforts and the opportunities to insert the Healthy Nations messages in

positive events conserved energies and reduced competition for participants and recognition.

Healthy Nations staff also learned other lessons, some through challenges that were difficult to overcome, such as expecting volunteers to assume most of the responsibility for events. Community acceptance and attendance informed programming and Healthy Nations development. The measuring stick determining program viability was the community's response rather than a conceptual model. The motto was doing more of what works and what the community embraces. This was most clearly demonstrated in the use of posters and tee shirts as promotion for wellness and Healthy Nations activities. The program tried newsletters, television and radio PSAs, and other media to inform community members of the philosophy and direction of Healthy Nations, but the director and staff soon discovered that these were much less effective and more expensive than the well-liked posters and tee shirts. The director reported that even today (2003) she sees kids and adults wearing tee shirts from Healthy Nations-sponsored activities. The wellness and anti-drug messages sharing the vision of "A Way of Life" community appear at the grocery store, council meetings, and tribal gatherings. These living billboards remind the communities to ask if these activities are going to be revitalized or resurrected.

The structure of Healthy Nations was shaped by the constantly changing political environment with its competing visions over the exact nature of prevention and community empowerment. Struggling to meet the requirement of the NPO as well as exhibiting a constant vigilance required to negotiate the tribal

politics, Healthy Nations staff learned to persevere and transcend efforts to stall the initiation of a partnership model of services. Many of the programs sponsored during Healthy Nations were systematically disassembled by competitive tribal factions, while others faded as funding ran out. Still, “A Way of Life” legacy is very much present. The Healthy Nations name continues to elicit fond memories from participants. Those touched and supported, especially the youth, are just now returning the favor. Calls to the tribal agencies and government continue to request resources for community-based projects. The Healthy Nations staff remains active and employed within the tribal system in different capacities and responsibilities.

Highlights:

During Phase I, Healthy Nations experimented with having its own sobriety powwow. Although quite successful, attracting at least 300 people in year two, it was in direct competition with the United Powwow. Recognizing the downside of competition and the increased efforts to duplicate the event facilitated the shift to a co-sponsor philosophy supporting established programs. The merger of Healthy Nations resources and messages with the United Powwow demonstrated the synergism of joining established events and the wisdom of a collaboration philosophy.

Using a holistic management style and the community survey data, Healthy Nations became a collaborator with many other programs. One such success was the Community Pride Ride, an all-day trail ride on horseback. The

program used hired horses and horse handlers to take kids and family members on day rides. The horse handlers and Healthy Nations staff taught them about the fundamentals of horsemanship, the connection to the earth, and traditional responsibility for animals. This program enjoyed unprecedented success and experienced a constant demand for more sessions. It drew from all four communities a cross-section of youth, adolescent, and adult participants. This program was such a success in helping kids bond together and with their families in a safe and sober environment that, following the cessation of the Healthy Nations program, it was made into a nonprofit organization and continues today.

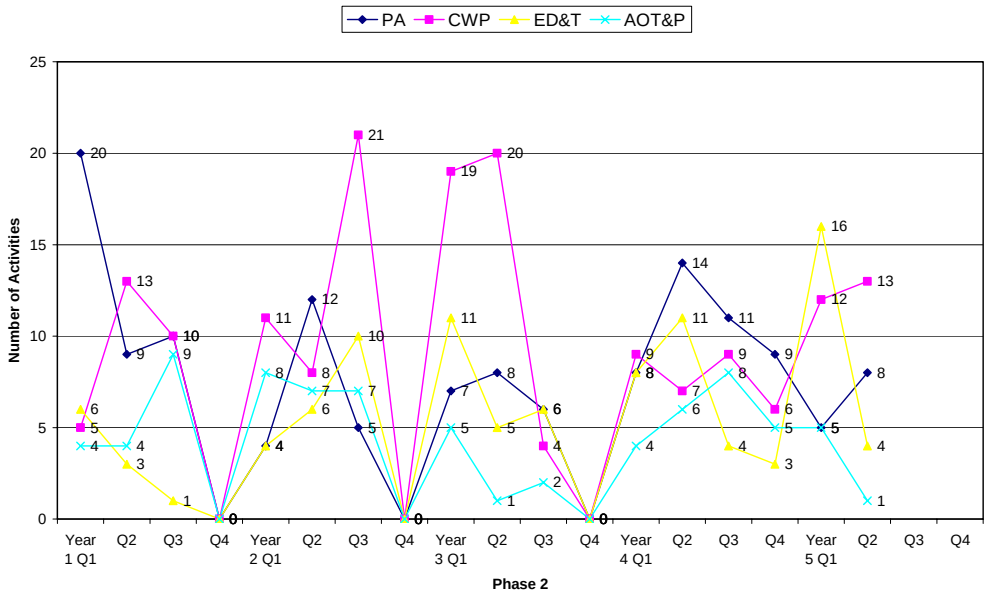
Collaboration produced a success mechanism to promote and manage many events as well as to create avenues for their post-Healthy Nations future. The Community Pride Ride was, and still is, co-sponsored with the Washington State University Cooperative and the 4-H Club. The United Powwow was sponsored by numerous other agencies including tribal agencies, local groups, and Healthy Nations. “A Way of Life” eventually joined with individual communities in group activities, in developing in-school curriculum, and in sponsoring DARE programs. Healthy Nations coordinated with the tribal council to pass ordinances that eventually helped to decrease access to taverns on the reservation. Learning from the examples set by Healthy Nations, the current tribal council formed community action groups. These local groups are charged with informing the council about community concerns and needs. The active listening model espoused by “A Way of Life” is an important component in policy making and tribal governance.

Healthy Nations' financial flexibility in supporting different community efforts, including ceremonial and traditional activities (i.e. hand drums and stick games), created a greater acceptance and demand by the communities. Successful activities were always guided by the acceptance of the community and judged by the number of people who repeatedly attended and by the lack of negative telephone calls.

The idea of feasible community change was just peaking at the time of the no-cost extension year when some of the first adolescent participants, now young adults, started to entertain the idea of giving back something positive to the community. This was an underlying idea that emerged from the Healthy Nations philosophy. It grew from the local action teams, from collaboration with existing programs, and from reconnection of families with the Elders and youth (particularly with their traditional roots). "A Way of Life" was not a cultural intervention; rather it became a movement to connect each of the different Colville bands with their traditional ways and holistic wellness. Each community as well as each group was able to generate prevention information and activities, discover and repair cultural relationships, and thus enhance the physical and spiritual dimensions strengthening their inner resolve to decrease substance abuse and related issues on the reservation.

The success of the Healthy Nations "A Way of Life" community was best summed up by the former director, who said that "Healthy Nations was the biggest step for the wellness on the Colville reservation."

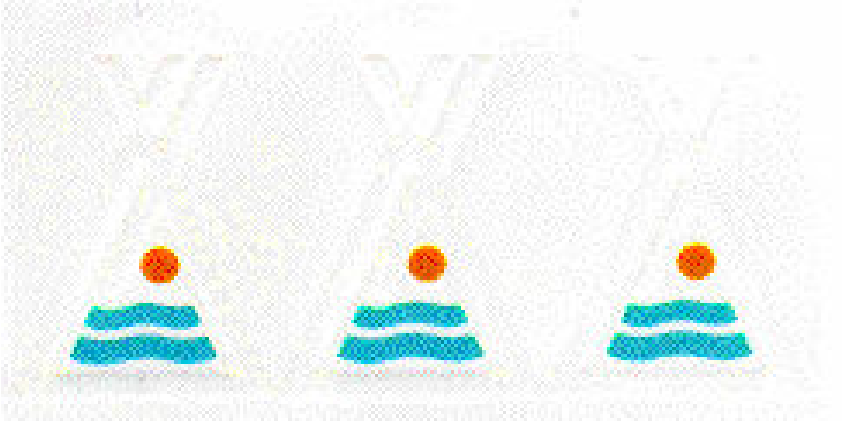
Colville Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Confederated Tribes of Warm Springs Reservation

Warm Springs, Oregon



Healthy Nations Program

December 1993 – May 2000

**“Changing the Norms and Reducing Substance Abuse:
Public Events to Private Actions”**

The Confederate Tribes of Warm Springs Narrative

Historical Context:

The Confederate Tribes of Warm Springs Indian Reservation is located in central Oregon. The reservation consists of 655,000 acres of treaty-reserved land that was set aside in 1855. It is a beautiful area, situated between the Deschutes River and the Cascade Mountain Range. This area was originally the home of the Warm Springs and Wasco Tribes. Later in 1882, the Northern Paiute Tribe was relocated to the reservation by the U.S. Army after the Bannock Wars. The Warm Springs reservation is home to about 5,300 Native Americans and is surrounded by approximately 122,000 people living in central Oregon.

The town of Warm Springs is the center of tribal government. The social service and health-related services for tribal members and their families as well as for non-Native employees are located there. The tribal government is structured as a tribal council, which includes lifetime representation by the chief from each of the tribes as well as eight members who are elected every three years. The Wasco and Warm Springs tribes each elect three representatives, and the Paiute tribe elects two representatives. It takes six council member votes to pass any ordinance. This governmental arrangement encourages negotiation and compromise.

Warm Springs has long acknowledged the negative impact of substance abuse and alcoholism on their members and on their reservation. The tribe has

experienced significant violence, death, and accidents as well as social disruption due to substance abuse. This acknowledgement by the tribal council led to the establishment in 1977 of a volunteer committee, the Alcohol and Drug Council (ADC). Originally appointed by the tribal council, this body, in 1982, was later ratified as a permanent government organization. This action at Warm Springs demonstrated the commitment to addressing and emphasizing substance abuse prevention and treatment.

Social indicators prior to 1993 indicate Warm Springs enrollees experienced higher rates of unemployment, mortality, poor education, and substance-related problems compared to the surrounding non-Native county. Reservation unemployment of adults over 18 reached 22.4 percent in 1991, three times the rate of the whole state of Oregon. High school completion in the same period was at 50th percentile, significantly lower than matched non-Native cohorts. A 1992 tribal health status report compiled data from 1985 to 1989 and found that four of five leading causes of reservation deaths were alcohol related. This data set also revealed a disproportionate negative health impact due to alcohol and substance abuse. Tribal police records documented over 2,200 annual arrests and remanding for detoxification in the correctional facility. Seven fatalities were recorded in 1990 due to motor vehicle accidents, all of which were alcohol related. Seventy-seven percent of completed suicides, 54 percent of all suicide attempts, and 85 percent of child protective reports and interventions were directly related to alcohol.

Tribal monitoring of student substance use began in 1986. The 1992 statistics confirmed the wide-spread problem with youth substance abuse. Surveys of 11th graders found that 65 percent had consumed alcohol in their lives; 53 percent endorsed current drinking. Thirty percent currently smoked marijuana, and a shocking 15 percent had used cocaine within the last 30 days. These data indicated the extent of the problem and, also, the fact that tribal leaders had knowledge of it.

The attending social and cultural disruptions paralleled these drug use trends. A high rate of suicide, violent crime, and loss of cultural identity plagued the reservation. A 1990 Behavior Risk Factor Survey noted that only 12 percent of the sample could understand their native language. Only one-in-ten persons reported connection with spiritual or ceremonial activities. This confirmed an earlier survey that indicated two-thirds of respondents in the community felt it was very important to succeed in the “white, American way.” Likewise, this survey revealed a ninety percent endorsement supporting the importance of retaining Indian and cultural identity.

The Alcohol and Drug Council (ADC), understanding the data, had been very active in undertaking prevention, intervention, and community support activities targeting substance abuse and recovery in Warm Springs. They facilitated the establishment of a no-smoking ordinance and helped to establish pre-employment drug testing and drug-free workplace policies. They guided the tribal establishment of the Community Counseling Center, which houses all direct substance abuse intervention programs. The tribe had forged strong partnerships

with local schools by offering substance abuse prevention programming. DARE, Healthy Options for Teens (HOT), and in-school education programs teaching coping skills are provided by the Community Health Promotion department. The allocation of resources, personnel, and attention to both the Community Counseling and Health Promotions departments verify the tribal commitment to addressing substance abuse.

Phase I:

The ADC and the director of the Community Counseling Center received the call for proposal from the Robert Wood Johnson Foundation. Representatives attended a pre-grant meeting in Denver. This exploratory group briefed the tribal council and received encouragement to submit a proposal. They felt that the scope of Healthy Nations would fit within the composition of the tribal services and would parallel their community outreach model.

The advisory committee prepared a proposal based on involving more community organizations. The model endorsed a “bottom up” listening program structure. The proposal presented a closer integration of the two community service providers as well as enhancing the ongoing outreach services. This model complemented the existing infrastructure that provided prevention, early intervention, and aftercare services. Their philosophy was to take those who had achieved sobriety in the community and help them take a more active role in developing social programs and activities to help others sustain sobriety. This community reinforcement model was based upon listening and empowering the

community through resources and informational support. They also anticipated that the Healthy Nation Initiative would augment and expand a smaller substance abuse prevention and public awareness grant received from the Presbyterian Church.

The ADC acted as the Healthy Nations' sponsor, tribal liaison, and advisory committee. Commissioned by the tribal council, the ADC was assigned as the Healthy Nations' grant managing body, and the program director of the Community Counseling Center was assigned the directorship. This arrangement placed the Healthy Nations project in a favorable position to support the communities and influence change in policy and treatment delivery. This leadership matrix was ratified by a tribal council resolution. Such a strong endorsement helped to guarantee fewer resource and energy diversions through intra-tribal politicking.

Warm Springs was a successful applicant and received the Phase I development and planning grant. They immediately began to initiate pilot programs addressing the four Healthy Nations grant components.

Phase I:

Phase I saw a flurry of public awareness activities, including radio spots on their locally owned radio station (KWHO) and in their local newspapers. Healthy Nations even established a newsletter. These media outlets were utilized to inform individuals of meetings and community opportunities to share ideas. This early period focused on community gatherings and eliciting feedback. One

crucial decision was the incorporation of the tribal long houses for gathering information and forming partnerships with community members. The long houses are centers of ceremony and social and tribal gatherings and also serve as the seat of spiritual and cultural events. Healthy Nations used these traditional forums to elicit ideas and encourage support for those who were making decisions for wellness and sobriety. Multiple meetings were held at each one of these houses and included hundreds of tribal members in the process of defining Healthy Nations.

The “hands off” philosophy of the ADC and the director allowed for a free flow of ideas. Phase I meetings generated nearly 60 ideas, of which thirteen were later untaken in Phase II. These thirteen ideas had enough community support and volunteers to make them viable. Phase I witnessed the initial transfer of Healthy Nations programming and project direction from the ADC and director to the local people. The role of the Healthy Nations program evolved as a distributor of resources and a supportive training agency for the community-driven initiatives. For example, local volunteers would submit a community activity idea along with a cost estimate to the Healthy Nations staff. The idea would be analyzed for viability and community support, and the staff would sponsor the idea and set about to provide the needed resources. Essential skills, including accounting and resource development, would be offered. Fiscal responsibilities would be managed in conjunction with the community leader. This partnership stance of Healthy Nations encouraged local ownership, taught organizational skills, and maintained the accountability to Robert Wood Johnson Foundation.

Transition:

The mobilization of the Healthy Nations program during Phase I was not without complications. The second Healthy Nations project coordinator, working under the director of Community Counseling, was a vivacious and well-known community member. Toward the end of Phase I and early in Phase II, this coordinator moved to another position. This unforeseen leadership change was compounded by natural disaster—a fire and a flood that also interrupted the gathering of the community members. Survival trumped the gathering of community wellness ideas and prevention activities. These two events introduced barriers to reaching the objectives of Phase I.

A different trajectory for Phase II objectives developed from this transition period. A new coordinator was hired; the disasters passed; and Healthy Nations resumed outreach to the communities.

There was also tension at the Phase II transition between Warm Springs and the NPO. Because of the nature of the projects and the philosophy of the Warm Springs Healthy Nations leadership (that being one of complete local control and listening to and facilitating community empowerment and ownership), reporting challenges arose. The NPO asserted that there weren't clear enough definitions and reporting in the categories as established in the RFP. The director and the communities demonstrated flexibility in the type of programs they supported. Documentation had not directly linked each one of these activities to one of the four Healthy Nation components nor expressly elucidated their role in

prevention or treatment. The accepted role of being a resource manager and distributor of skills and material to viable ideas without direct prescriptive oversight conflicted with the reporting conditions of the grant. It was difficult to document the natural development and shifts in the community application of prevention in the requested format for grant compliance. This management style and grant interpretation led to significant discussions between the NPO and Warm Springs director during the next year and a half. The resolution was to increase Healthy Nations staff effort to link the activities to RWJ components and, likewise, the NPO agreed to become more accepting of the flexible and broad community efforts.

Also, silent grudges had developed during this period by some allied agencies. The initial successes of Healthy Nations-sponsored events, the perceived windfall of flexible funding, and strength of tribal influence spawned a "wait and see them fall" stance. This growing distance limited cooperation and stymied other collaborative efforts. In the background was this negative attitude that would present obstacles through the life of Healthy Nations. Nevertheless, the Phase II proposal, having met little resistance from the ADC or NPO, was ratified and implemented.

Phase II:

"When government calls a meeting, you don't get change; but when citizens call a meeting for the government, you are more likely to see something different happen" noted the Healthy Nations director. This Phase II philosophy of

mobilization underscored their ongoing effort and success to draw upon local resources, generate local volunteers, and bridge communication gaps.

Many of the thirteen Phase II ideas were successful. Others were less successful because they were either developed for personal reasons or based upon a particular skill of one individual. These program problems and failures served as learning opportunities and were used to inform the next generation of Healthy Nations activities. For example, the After-School Gymnastics Program discontinued because the instructor took other employment and moved from the community. The children involved in this particular program were left without their activity.

Some projects produced positive results transcending the expectations and predictions of the director. One, the Community Gardening project (which still holds the sign of “Community Garden Robert Wood Johnson Foundation”), was conspicuously placed next to the tribal offices. A local gentleman plowed the ground with the help of other local tribal members. They planted cucumbers and corn. Tribal members joined in by sharing in the planting and in the harvest—all under the constant view of the tribal leaders and Healthy Nation staff. Elders and other tribal members came; the garden revitalized community ownership and sharing. These important concepts are based on tribal relationship and local kinship principles that demonstrated protective power in earlier generations. This successful and simple project lasted three years of Phase II. The farmer eventually moved on, and the lot sat empty the last year. Still standing, the

placard announces the intention, possibility, and success of community effort and traditional cooperation. There is ongoing discussion about reviving this project.

Healthy Nations encouraged community organizers and volunteers by providing support through the long-house meetings and other community gatherings. By sponsoring dinners, granting awards, and giving tee shirts, they recognized their volunteers. Public acknowledgement in radio spots and newspaper messages helped to maintain the volunteers' efforts as well as to advertise the activity. This increased the number of people who joined the grassroots movement and distinguished themselves as community leaders.

The relationship between Healthy Nations and the communities matured, deepened, and bore healing fruits. Many other activities were attempted; not all were successful, but efforts were recognized. Most importantly, local communities felt empowered, and the idea of being sober and pursuing wellness became increasingly more broadly accepted. Gatherings and events—previously alcohol-infused and -disrupted—became relatively drug free; the old behavioral standards were no longer tolerated. This change in acceptance affected such gatherings as funerals, tribal parties, and business meetings. The idea of being positive role models, dealing directly with drunkenness, and not accepting the resulting violence and social disarray has become institutionalized by the philosophy and activities of the ADC and Healthy Nations.

Phase II was not without distraction and challenge. The "wait and watch them fall" stance flared at times into an active "try to trip them" behavior. The director led Healthy Nations through this period by initiating personnel changes

and remaining focused on the volunteers and their community projects. Using strong argumentation to the tribal council and by renewed support for the communities and volunteers, Healthy Nations remained vital and strong. The successes of many community programs helped to quell any posturing and barrier building.

Ongoing grant compliance challenges served to define leadership and mature the Healthy Nations concept. The NPO indicated that insufficient effort was placed directly on aftercare. Among the community efforts, direct aftercare components were not outlined. The response of the director and ADC was that they had an institutional aftercare component under the Community Counseling programs. Warm Springs leadership contended that they needed to have sober alternatives, culturally and traditionally based, in the community. They discussed with the NPO that future sustainability necessitated divestiture from formal, professional services. This was consistent with community ownership, the partnership philosophy, and cultural values. Such activities and community programs were supports for early recovery and the re-engagement of members into the community. Communicating and reporting this linkage proved challenging but central in the relationship to the national office. Eventually, the understanding between the NPO and director facilitated less concern about the individual grant components. This allowed more global support for the Warm Springs model.

Highlights:

One of the successful community-driven ideas was a youth rodeo called “The Mother’s Day Rodeo.” A children- and youth-specific rodeo, it drew strong memories of historical gatherings. The first year it was not unusual to have aunts, uncles, mothers, and fathers show up drunk at this activity. The organizers, community leaders, and volunteers chose not to tolerate this and sent a sobriety message by calling the police. Many of the inebriates were arrested or escorted from the rodeo grounds. A strong message was sent to and, more importantly, was received by the community. From that point on, Healthy Nations programs were seen as seriously sober gatherings.

The Mother’s Day Rodeo continued to grow each year and was ultimately subsumed into a traditional celebration held on traditional ceremony grounds at the foothills of the Cascade Mountains. The rodeo was combined with the Huckleberry Festival, which had been declining for a number of decades. As a ceremony of harvesting nature’s abundance, joyful thankfulness, and the community’s preparation for winter, the Huckleberry Festival had gradually lost importance for a majority of the community. Combining the Huckleberry Festival and Mother’s Day Rodeo made the gathering both institutional and permanent. From a successful 150-participant event the first year to the 700 family members joining the Huckleberry Festival this last year, this little rodeo spawned pride in tradition, increased tribal cohesion, and promoted a safe and sober gathering.

The philosophy of community-driven, culturally informed, and locally owned projects sometime defied the categorization of the projects. The

Huckleberry Festival with the attendant revitalization of the associated long-house rites, an increase in ceremonial traditions, and sober gatherings for community members spans the categories in the grant objectives. Warm Springs Healthy Nations realized that raw numbers of participants and activities in the categories were less important than community pride, a feeling of ownership, and the demand for more such activities and volunteers.

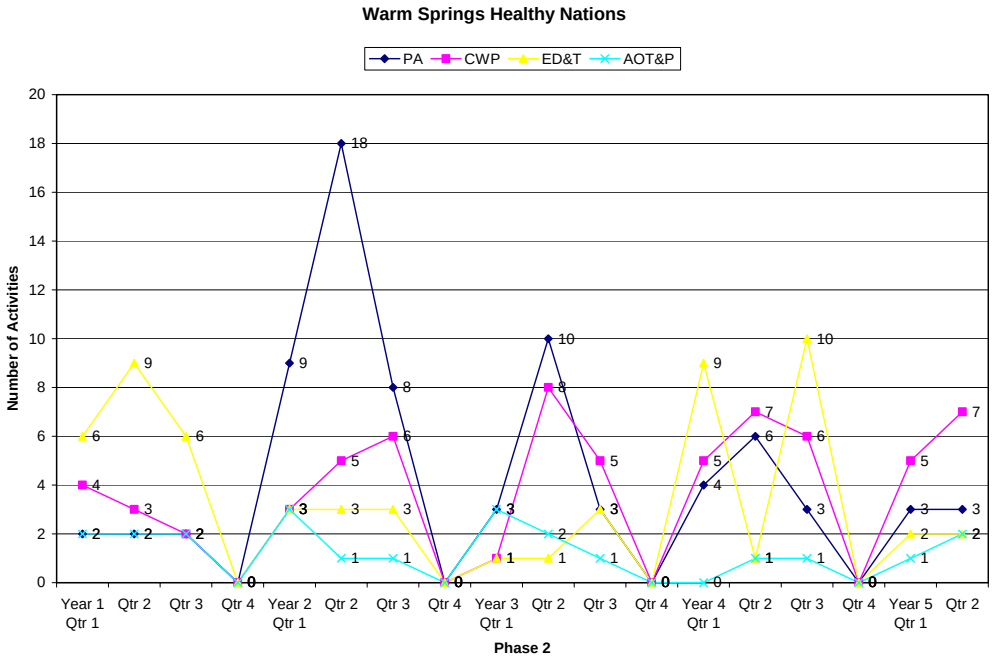
The annual Halloween party is another prime example of the changes in social acceptance of substance abuse on the Warm Springs reservation. Historically, this party ended with 300 people in jail because of drunkenness and disorderly conduct. Healthy Nations added its sponsorship, including positive messages about wellness and sobriety, and transformed the Halloween party into a healthier tribal gathering. Today, this event is safer and more family oriented, providing sober and healthy fun along with conveying positive messages about lifestyle choice, relationships, and interpersonal respect. Healthy life choices are being demonstrated to young children and youth from the Elders and the sober community. The occasional drinking incident is met quickly with action and separation. A new social climate has developed.

Community volunteers and project organizers remain positively engaged in community activities and stand as voices for sobriety and wellness. Individuals who were associated with event leadership have remained in the circle of support and sobriety. The director of the Community Counseling Center continues in his role, implementing the philosophy of inclusion and listening. The administrative assistant moved into a position of prevention specialist and is helping to run tribal

prevention programs. The school liaison remains engaged in curriculum development and teaching positive lessons about culture and healthy lifestyles.

The greatest resource developed was that Healthy Nations helped individual volunteers who organized community programs gain valuable skills and public recognition. Unexpectedly, many gained the respect and authority necessary to move up in the long-house government system. This human resource outcome helped to focus on cultural identity, ceremony, and spirituality—recognized components for positive community growth and health status at Warm Springs.

Healthy Nations ideas and philosophies are being further institutionalized through a program called “Youth Development.” This current program combines state prevention dollars and tribal resources. It is a comprehensive program which includes many of the same Healthy Nations-supported activities as well as a crime reduction component. With a definitive increase in sober activities as well as revitalization of many of the cultural and traditional activities, the road to wellness has been paved, leading to the place anticipated by the Elders, dreamed about by the leaders, and partially realized by the community. The efforts of Healthy Nations, supported by the tribal council and the ADC, helped to enhance a greater consciousness of cultural and social obligation concerning sobriety and the recognition that the answer lies within the community.



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Eastern Band of Cherokee

Cherokee, North Carolina

Healthy Nations Program

December 1993 – November 2000

“Many Hands and Different Visions:
Moving from Community-Wide to Individual Towns”

Eastern Band of Cherokee Narrative

Historical Context:

Located in the Great Smokey Mountains of the western part of North Carolina, the Eastern Band of Cherokee occupies a fraction of their ancestral homelands. The “Qualla Boundary,” or reservation, has shrunk from a historical territory of over 53,000 square miles, encompassing parts of six states in the 1830s, to the approximately 56,000 acres of the reservation today. The current reservation extends into five counties: Cherokee, Graham, Haywood, Jackson, and Swain. The “Qualla Boundary,” the most contiguous portion of the reservation, covers mountainous forests with a narrow easement along the main waterways. The rest of the tribal lands are composed of small tracts of land spread along a 60 mile corridor west from Cherokee, North Carolina, the home of the tribal headquarters and services. The Qualla Boundary encompasses ten primary communities: Big Y, Soco (Wolfe Town), Paint Town, Big Cove, Powstream, Yellowhill, Bird Town, Snowbird, Cherokee County, and a 3,200-acre tract. The beauty of the land as well as being the gateway to the Great Smokey Mountains National Park has provided the Eastern Band of Cherokee a reliable natural resource in tourism. The recent addition of a tribally owned casino has increased the draw to outside dollars.

In 1988, the total population of the Eastern Band of Cherokee members was just under 10,000, with almost 7,000 of them living on reservation lands.

These enrollees are part of the larger Cherokee Nation family who were driven from their ancestral lands in the late 1830s. Organized and executed under Congressional order and with military escorts, the “Trail of Tears” march divided this once “most civilized” tribe. The original tribe, known as “Yun-Wi-Yuh” (meaning “Principal People”) fractured into two groups: (1) those that made the trek west, or Western Cherokee of the Cherokee Nation, and (2) those who escaped into the hills, refused to go, or afterward returned home, called the Eastern Band of Cherokee. This history of distasteful relationships, broken treatises, and land losses with the U.S. government colored the development and early organization of this people. Finally, after a relatively recent amendment to the Indian Charter of the early 1930s, the Eastern Band of Cherokee became responsible for the government of the reservation.

The tribal government is modeled after the American Constitution, including a legislative branch consisting of twelve elected tribal representatives. These public figures serve two-year terms and are elected from different political subdivisions on the Qualla Boundary. The Executive Branch is composed of a Principal Chief, a Vice-Chief, and an Executive advisor. These positions are elected at-large every four years. The judicial department is a Tribal Code of Federal Regulation court system. Each community on the Qualla Boundary is governed by a Club. These Clubs have elected officers that regulate community activities and act as gatekeepers and spokespersons for the community.

Those residing on the Qualla Boundary are beset with poverty, substance abuse, and diminished health status consistent with the national trends of

American Indian communities. The Eastern Band of Cherokee (EBC) is predominantly younger than non-Native communities, with 42 percent of the EBC members younger than 25 and 23 percent under age 15. The Qualla Boundary lacks sufficient resources for many permanent jobs outside tourism and gaming resulting in 34 percent living at or below poverty level. Some 63 percent of the families are considered low to moderate income. Without tourism, these numbers would be more drastic and stark.

Education is provided on the Qualla Boundary but is funded at two-thirds the level of the state of North Carolina. The combination of poverty and insufficiently funded education generally creates social and individual problems, including increased alcohol and substance abuse. These issues have been addressed by the Tribal Health Delivery System and the tribal government.

The Health Delivery System has been managing health programs and health service funding since 1972. Under the PL 93-638, the tribe has administered the IHS services and hospital. Chemical dependency and alcohol treatment are identified problems that have garnered attention and resources from the tribe. The 1992 organization chart includes an inpatient substance abuse department and the behavioral healthy services division. The proposal for Phase I Healthy Nations funding cited an informal survey of tribal employees indicating 90 percent have been personally impacted by alcohol and substance abuse. A 1991 Cherokee Center of Family Services report showed 86 cases of child neglect and abuse with 129 referrals to Family Services parenting program. It is implied that the majority of these were alcohol- and substance-abuse related.

The youth on the Qualla Boundary experienced substance abuse at a rate greater than the surrounding non-Native communities. Based on the connection between esteem and substance use, the tribe cited a survey using the Tennessee Self-Concept Scale demonstrating that Cherokee youth scored on average one standard deviation below the national mean. This realization had prompted the tribal schools to institute a curriculum targeting substance abuse for all school-age children.

Tribal government responses to the substance abuse problems have been punctuated through the 1986 Omnibus Drug Act and subsequent revisions and tribal plans. These efforts have been in two basic directions. The first was a series of resolutions and referendums aimed at reducing substance abuse and access on reservation lands. The Tribal Specific Tribal Action Plans have successfully blocked two attempts to allow the sale of alcohol on the Qualla Boundary. The 1993 Action Plan concentrated on three areas of service coordination, health, and prevention efforts. Tribal resources and planning sought to better coordinate the services to those suffering with substance-related issues and their families, to increase prevention activities that addressed alcohol and substance abuse topics, and to integrate those agencies that work with youth. Those providing services and leading the Eastern Band of Cherokee fully recognized the negative impact of alcohol and illicit drugs on their people, culture, traditions, and general well-being. This understanding set the stage for their preparation for and solicitation of Healthy Nations funding.

Phase I:

"Project Healthy Cherokee," the title of the proposed Eastern Band of Cherokee Healthy Nations program, represented collaboration among Tribal Health Delivery System, Cherokee Central Schools, and the Rural Family Friends organizations. The submittal was supported by the tribal council through a general resolution. The composition of the proposal reflected the Tribal Action plan and included efforts to survey the communities as well as developing a coordinated system of services and prevention activities on the reservation. The intent was to enhance cultural and traditional components in the existing programs as well as to integrate strategies to bolster prevention through community participation and youth activities. The Eastern Band of Cherokee proposal was supported by most members of the National Advisory Committee and, after discussion and negotiation, approved and funded for Phase I.

Project Healthy Cherokee was housed in the Health Planning department of the Health Delivery System, which allowed for the best coordination of services. The first director was joined by a coordinator and an outreach person. The first task was a survey of the communities, demanding travel to each community, meeting with Club members, and utilizing the natural communication systems to gather information. It was not a formal survey and lacked a defined structure; it was more an intimate conversation about the community's needs and wishes. This process of community connection became a standard of practice throughout the full grant period.

Attempting to forge a greater sense of community across the Qualla Boundary, Phase I activities included the first cultural camp. This activity drew some 150–200 people who joined together in traditional games and meals. Such camps were projected to be a central mechanism for the prevention and cultural enhancement processes outlined in Healthy Cherokee goals. Other activities of Phase I included the distribution to the communities of posters and newsletters carrying anti-substance use messages. The staff undertook to calendar those reservation-wide activities that provided healthy messages and opportunities. This was the first attempt at coordinating services among the many providers and agencies.

The staff discovered that these community-wide events were demanding. This first experience exposed the complex nature of prevention programming. Organizing large community gatherings underscored the intent of Eastern Band of Cherokee's Phase I objectives and philosophy. The plan was to support ongoing activities like the women's cancer walk and other established events. Such experiences and learning were later translated into a shift of philosophy and objectives for Phase II.

Phase I also saw considerable struggles and challenges that nearly undermined their opportunity to move into Phase II. Personnel changes in both director and coordinator positions interrupted the evolution of the project. Healthy Cherokee experienced fits and starts as the community learned of the project only to witness the shuffle of personnel that inevitably changed the face of the objectives and public presentation. Other difficulties arose around the grant

reporting demands. Described as difficult and unusual, the directors were always in arrears in reporting the activities of their grant. This created a concern among the NPO and stimulated sites visits, reported to be seen as nerve racking and scary. Concern about not meeting the expectations and demands of the NPO and the grant stipulations created a tension among the staff and consumed resources and attention. The lack of reporting and the nature of the site visits overshadowed the efforts and beginning evolution of the Healthy Cherokee programs and philosophy.

Transition:

The transition into Phase II was very rocky and disjointed. The change in personnel and the panic that accompanied reporting left the proposal dangling until only eleven days before the deadline. Those who were associated with the program and had administrative oversight recruited a seasoned IHS manager from the tribe to literally rescue the proposal writing. The process was eventually completed but not without a technical support site visit. There had been discussion among the NPO and NAC about the viability of the project, but with strong advocacy from supporters, the program was maintained.

The nature of the Phase II proposal was a shift away from community-wide programs and camps to a more community-specific focus. Not formally abandoning the best of the general prevention strategies, Phase II took much of its structure and direction from the University of Washington's "Community that Cares" program. But even before a solid implementation of some of the Phase II

objectives could be initiated, personnel changes again rattled the program—the Chief changed as well as the director and coordinator. The program lacked the ability to maintain consistent management. Each director offered a different interpretation of the intent of the grant, had to learn the system and, subsequently, compounded the reporting and development problems that compromised the Healthy Cherokee viability. The transition period remained uneven well into the implementation Phase II.

Phase II:

The relationship with the different communities exposed the diversity and unique needs of each town. An outreach coordinator for Healthy Cherokee continued to visit each town, speaking with the Club members and listening at community meetings. The foundation of listening and not imposing ideas produced insights and participation at the community level. A general theme of community pride was translated into a beautification project. Utilizing a sense of ownership and encouraging self-esteem through enhancing the living environment, Healthy Cherokee sponsored community projects such as community billboards that sent welcoming and healthy messages, hanging bird houses to encourage the return of wildlife, and general clean-up projects.

Engaging the youth with community volunteers and Healthy Cherokee staff targeted their pride and self-esteem. The belief and theory was that strong self-esteem decreased the susceptibility to drug use and negative social behaviors. Although the intent of Healthy Cherokee was to involve all age groups

living on the Qualla Boundary, most of the programs addressed the youth. One such program that drew the youth was community beautification. Other efforts such as development of school-based programs, sport activities, and youth leadership were more directly related to youth and consumed a majority of the efforts for the next four years.

Trouble with personnel continued. The project in Phase II had three different directors and numerous coordinators and outreach workers. This constant turnover in leadership and staff continually interrupted many programs and decreased the effectiveness of the program in general. By the end of year two of Phase II, the staff's insecurity working in a grant environment was compounded by more financially attractive employment at the Casino.

Changes in staff dominated the Healthy Cherokee program and scrutiny of the NPO. Early year three experienced more changes in the tribe and program. Elections were held and a third Chief was elected, but the tribal government remained supportive of the program over all.

The NPO continued to work with the staff to improve the reporting system and encouraged more complete attention to the entire four RWJ components. Community-wide prevention and public awareness had received a disproportionate level of effort. This disparity was never fully remedied, but the program continued on into a fifth year of carry-over funding. The final two years experienced a relatively stable personnel corps that contributed to increased successes and the transfer of philosophy to current programs. The final director and coordinators demonstrated a dedication and level of energy hoped for in the

initial proposal. Reporting improved, programs were carried out with great success, and the intent of Healthy Nations was better realized. The final chapters were much smoother. Leadership stability as well as a different relationship with the NPO redeemed the program and set the stage for the future. In the end the program provided many viable opportunities to each community and to the youth of the area. This contribution continues to impact the lives of the Cherokee people in North Carolina.

Highlights:

Consistent with an original goal of developing youth leadership, Healthy Cherokee sponsored a very successful youth council training. Known as “Junaluska,” named after an early Cherokee leader, this program provided for 20 youth to participate yearly in tribal government. Participation was not based on grades and extracurricular activities but was open to all students willing to be drug free and to attend meetings. Junaluska taught debating skills and problem solving and included a mentoring program connecting these youth leaders with seated council members. The group would be responsible for assessing needs of their school, communities, and nation and would develop feasible plans and present resolutions to address the problems. Aimed at preparing future leaders and enhancing self-esteem, Junaluska has reaped great rewards. Most of those that participated have either gone on to the university or are productively employed. The last director stated that, to her knowledge, most remain substance free.

The community billboard project remains a visible testament to the Healthy Cherokee activities. Prominently placed on thoroughfares and entrances to each community, these signs remind residents and visitors of something unique to that specific community as well as conveying a message about wellness and sobriety. The beautification mentality has continued in many of the communities, producing a sense of pride in their environment. Many of the youth involved with these projects are about to enter into the Clubs to help direct the future for these communities. This project utilized traditional understanding about the earth, building on the philosophy of culture as protective.

Cultural and traditional messages as well as the introduction of healthy alternatives were promoted throughout the Healthy Cherokee project. The “One Feather” newsletter always carried positive acknowledgements of Healthy Cherokee sponsorship and the effort of participants. Individuals and groups were spotlighted, sending the message that respect and acknowledgement followed positive activities. These printed diaries of Healthy Cherokee speak of the strength and earnestness of the many volunteers and the staff of Healthy Nations.

Sporting events and youth soccer leagues drew large crowds of youth and their parents and were used as opportunities to present pro-social and culturally relevant messages. Direct talks and lectures about abstinence and substance abuse were not the tactics taken at these events; rather relationship building, connecting with healthy role models, and gentle teaching were the methods most culturally consistent. Education and prevention were given in small doses.

Participatory learning, reinforced with positive relationships and fun, was the model of prevention and public awareness at these gatherings. Healthy food was consistently substituted for the usual picnic fare, serving as a model and reminder of the commitment to well-being through action, eating, and culture.

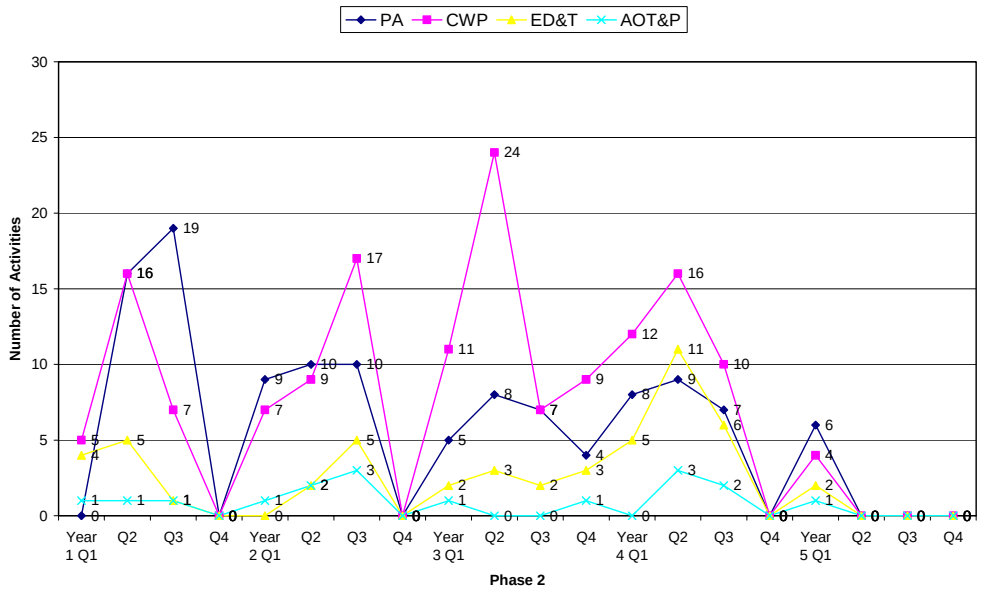
The presence of Healthy Cherokee at so many events, the joint sponsoring, and the investment of the staff's time, especially during the final two years, moved the project from a program to a common motto currently incorporated in ongoing programs. The name "Healthy Cherokee" carries a recognized power and represents the hope of the Health Delivery System.

However, not all cultural activities bore fruit. Trying to incorporate more traditional and Native components into treatment and aftercare, Healthy Cherokee encouraged the use of sweat lodges. This was only marginally accepted because Cherokee people have not historically used this ceremony. Nevertheless, the effort to expand the models of treatment to include more tradition increased dialogue and inclusion of local ideas. Traditional cooking, cultural pride, crafts, and hunting gained a place in the community and individual lives at Eastern Band of Cherokee.

The personnel turnover was excessive and extremely disruptive. However, such problems also produced a cadre of employees who were exposed to the philosophy and structure of Healthy Nations. The ideas and concepts continue, in different iterations and packages, across the tribal system and even into the private sector. Many of the directors and coordinators continued in the community and intersected with the Healthy Cherokee staff. The concept of

community and culture continue into a new Healthy Cherokee program. Capitalizing on the name and recognition of its strengths, the Eastern Band of Cherokee is conducting a diabetes prevention campaign in which most of the components of Healthy Nations are incorporated. The coordination of services and the inclusion of physical health and spiritual well-being form the foundation of this diabetes effort. The behavioral health department as well as the whole Health Delivery System contains aspects of the vision of Healthy Cherokee and Healthy Nations. The Eastern Band of Cherokee Healthy Nations program never fully matured but did generate some lasting institutions and the infusion of a community- and cultural-based philosophy.

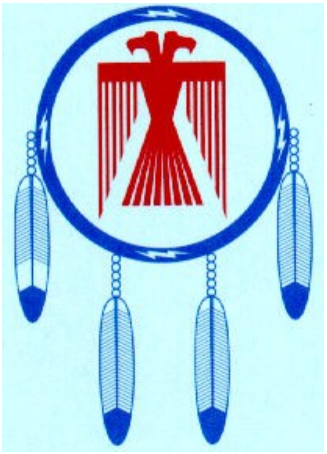
Eastern Band of Cherokee Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Friendship House

San Francisco/Oakland



Healthy Nations Program

December 1993 – December 1999

“Pan Indian Values Rise from Attempt to Unite Many Agencies: From Too Many to a Strong Few”

Friendship House San Francisco/Oakland Narrative

Historical Context:

The Healthy Nations “Circle of Strength” program of the greater San Francisco area was one of fourteen national grantee sites. A consortium of American Indian agencies joined together to address prevention services in the seven counties of the Bay area: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and San Joaquin. The largest urban site of all grantees, the Circle of Strength covered more than 37,000 American Indians and Alaska Natives living in the catchment area. Lacking a central community structure, concentrated American Indian neighborhoods and identified intersections with non-Native populations, the Greater Bay area is a frequent place of relocation for those leaving reservations.

The Native population is very mobile and transient within the area, with individuals frequently moving from neighborhood to neighborhood. These frequent moves between urban and rural centers as well as multiple relocations within the catchment area create difficulties in maintaining consistent links with needed services and the community cohesion necessary for cultural survival. The common bond and access to other Native Americans is a network of Indian agencies providing social service, medical and dental, educational, and welfare supports. These institutions also provide much of the traditional and cultural contact for many of the Native residents.

Other dimensions of the American Indian groups in the Bay area highlight the struggles faced living in this urban setting. The population is considerably younger than the surrounding non-Native populations with a higher percentage living in poverty and single-parent homes. Due to the economics and infrastructure deterioration in urban areas, American Indians and their families are experiencing an accelerated plunge into increased unemployment, poverty, and the consequential social problems which include substance-related morbidity and mortality.

In 1993 the American Indian Cancer Control Project research concluded that twice as many Native adults used cigarettes and smokeless tobacco than the general U.S populations. The data also indicated that the urban population used these substances more frequently than their reservation counterparts. Other data of the same period indicated that California American Indians suffered roughly a ten-fold alcohol-related death rate than that of the general California population. A 1985 mental health survey conducted by the American Indian Child Resource Center showed that 54 percent of Native Americans in the catchment area suffered some kind of major mental health concern. The data also suggested a conservative 51 percent co-morbidity of substance abuse.

The Native youth cohorts paralleled the statistics of the Native adult populations. The Greater Bay area reached or surpassed the well-known national trends of extreme rates of alcohol use and abuse among Indian youth in grades seven to twelve. Native youth were dropping out of school at a rate 50 percent

higher than their non-Native peers. Opinion held that alcohol was the major factor influencing one of every two Native school dropouts in the Bay area.

Underscoring these data was the sense that community diffusion, cultural disassociation, economic uncertainty, and poor integration into the mainstream system were primary contributors. One such indicator reported that 45 percent of the Indian children in foster care received special education services or individual education programming. This is many times greater than matched, non-Native foster children. Associated problems of violence, gang activity, street living, criminal activity, and premature death plagued all Native Americans but were more pronounced in urban areas like San Francisco.

Recognition of these social ills and the disproportionate impact on American Indians had been issues for years among the many Bay area American Indian agencies, both federal and local. Efforts and programs sponsored by these providers attempted to fill the gaps left by loss of culture, breakdown of community, and traditional alienation, currently substituted with substance abuse and attendant negative lifestyles.

Widely recognized for excellent services for Native people, Friendship House Association of American Indians had provided support to substance-abusing American Indians in San Francisco for over two decades. The residential drug and alcohol program had received two commendations from the Indian Health Service. A 20-bed primary residential treatment, it offered a two-phase program consisting of 90 days of in-house treatment and 90 days of graduated aftercare contact. Added to the strength and recognition of the program, the

Friendship House Residential Drug and Alcohol Treatment program is the only fully licensed American Indian program targeting the Native abuser in the state of California. This status and reputation placed Friendship House as a primary partner in the consortium competing for Healthy Nations funding.

Another significant member of the Circle of Support consortium is the American Indian Family Healing Center, originally known as White Cloud Lodge in the 1970s. The Family Healing Center specialized in treating Indian women and their children who were experiencing substance abuse and related problems. Similar to Friendship House, the Family Healing Center is unique in the constellation of area Indian services providers.

The Healthy Nations steering consortium also extended across the Bay to Oakland. The partnership included the American Indian Child Resource Center. This agency was devoted to foster care of Native children under the Indian Child Welfare Act and included teaching parental skills, support, and advocacy. The Child Resource Center, through an Indian Education grant, provided tutoring and school support for elementary and middle school Native students.

The consortium of agencies included the two primary care organizations—the Native American Health Centers in both Oakland and San Francisco. Other groups joining the request of Healthy Nations funding included the American Indian Center of Santa Clara, including their Four Winds Lodge and Three Rivers Lodge Residential Alcoholism Programs; the United Indian Nations, Inc., which focused on economic development for Native people; and the Intertribal Friendship House, facilitating cultural contact and renewal through sponsorship

of Powwows and Native gatherings. The University of California at Berkeley was an active participant in the consortium. Their American Indian Graduate program and Native American Studies supplied information, data, and early direction. All these different agencies had provided a continuum of services in the different sectors of the Bay area. This group of agencies and some 20 others had, for years, been meeting under the name of Circle of Strength (COS). The agenda had been to address substance abuse and the risk factors known to contribute to the continued deterioration of the American Indian health status. The Robert Wood Johnson Healthy Nations call for proposals drew all of them again to the table to create the proposal to address substance abuse in their Indian communities and individuals. Early meetings created a sense of solidarity, mutual goals, and commitment to strengthen their network and coordination. A core group of the members of the COS composed, submitted, and eventually constituted the Healthy Nations advisory committee. Circle of Strength consortiums competed well and received the planning and development Phase I Healthy Nations Grant.

Phase I:

The Circle of Strength advisory committee had proposed a traditional medicine model addressing seven major components: public awareness, youth-focused prevention activities, aftercare enhancement and coordination, better early intervention and referral, creation of a robust volunteer corps, organizing an Elders advisory board, and outlining seven caregiver programs targeting general

wellness. After receiving the grant, the COS began a modest public information campaign. The messages were aimed at increasing name recognition of the Healthy Nations program along with highlighting substance abuse issues.

Phase I initiated and completed a seven-county demographic profiling of the American Indian population—the first time in history that this had been accomplished. The University of California provided substantial support and technical assistance in this endeavor. Efforts at strengthening treatment options created “Talking Circles” for adult clients in treatment and aftercare. Curriculum-based programs targeting school-age children underwent early development. Complementary to the original thirty-two goals and objectives, the Circle of Strength conducted numerous community visioning meetings. This was a canvassing of local leaders and members, eliciting ideas and suggestions about how to attack substance abuse and related problems including associated health concerns.

The consortium selected the Friendship House Residential Treatment program as the administrative and fiscal agent for the Healthy Nations grant. This early choice provided a good foundation for a later shift in overall management responsibilities. Staff acquisition and leadership assignments demanded effort and time. The nature of the COS was such that cooperation was many times beset with territorialism, competition, and disparate visions for the program. During the brain-storming time of this group, the University assumed a greater leadership role, ultimately producing a leadership matrix not supported by all parties. This accentuated critical internal consortium differences and led to

dissention in the group and, in some cases, precipitated withdrawal of membership and support. Among the frequent topics of discussion were resource allocation and how to divide the money between the member programs. Contentions over leadership, money, and the Healthy Nations vision progressively fragmented the COS and impacted objective fulfillment and the completion of Phase I planning and execution.

Many pilot programs were initiated based on the original strategic plans, the visioning meetings, and input from Elders and traditional healers. Lectures were held to address tobacco use, and other workshops addressed general health concerns. Healthy Nations staff compiled culture stories and traditional lessons designed to impact pre-school-aged children. This early prevention effort resulted in the formation of the Parent Advisory committee. This committee continued, throughout the grant, to promote storytelling education for American Indian children.

Another early public awareness activity was the creation of a fourteen-minute video produced by the Center for American Indian Research and Education and used by the University of California at Berkeley America Indian Graduate Program. The video, shown to numerous youth and school groups, underscored and highlighted the detrimental use of tobacco.

One Phase I objective was to help facilitate easier and better access to all Indian-associated services. Using an existing clearinghouse telephone line named “Warmline,” COS attempted to create a single-source referral and information process connecting all providers servicing Native peoples. While a

worthy and logical project, the cost was underestimated and available grant funds were unable to meet the growing expenses. Upon review, however, it was discovered that this effort was a duplication of another general referral line. Including this referral number eventually replaced “Warmline.”

Phase I experienced the disruption of leadership changes, intra-agency politics, diffusion of vision, and an over-ambitious proposal. Rising from the struggle was a small core of providers who migrated to support a central agency model for the upcoming Phase II implementation grant. Notwithstanding the challenges and fragmentation of the original consortium, Phase I had refined the COS youth-prevention focus and revitalized and increased traditional themes into the continuum of available treatment interventions. From these experiences, data, and suggestions, the Circle of Strength Healthy Nations project became a changing group of agencies which looked forward to the implementation of Phase II.

Transition:

Shifting from the development stage to the implementation phase was wrought with distractions, barriers, and complications. The COS core committee continued to shrink while the politics of the breakup consumed significant attention and energies. The second in a series of program directors was guiding the transition when an abrupt leadership change disrupted the trajectory. The series of leadership shifts, combined with a significant erosion of the consortium cohesion, demanded NPO intervention. This meeting and consultation generated

the consolidation of administrative and management responsibilities. Friendship House Residential Treatment Center, the original fiscal agent, was given sole responsibility for fiscal and all programmatic components. Clarifying the structure of the grant in Phase II as well as concluding the tug of war over control and direction, this management shift stabilized the project. The third and final director was appointed. He had clinical expertise, knowledge of the population, and a strong corporate structure surrounding him. The new leadership matrix consisted of a strong and consistent staff made up of an assistant director, a care manager, and a youth coordinator. Fiscal reporting was systemized and the programming was subsequently organized and monitored through a single agency. The ideals of the Circle of Strength philosophy of cooperation were still ambitious, and the goal was complicated by the disintegration of much of the agency network. Some consortium agencies faltered in producing expected deliverables while others withheld efforts, leveraging to get a piece of the funds. The new leadership confronted these realities as well as assumed short notice responsibilities for upcoming events.

Phase II witnessed a consolidation of responsibility and leadership under a single agency. Most efforts continued to be focused on youth prevention activities using tradition and cultural components and the stabilization of the remaining core committee's prevention and treatment program coordination efforts.

Highlights:

Connecting youth with their tribal and family history and familiarizing them with culture and traditions was a central tenet of COS. Drawing together the youth into pro-social and healthy alternative events as well as providing educational opportunities to develop esteem and skill was primary. Learning traditional songs and custom dances, reconnecting to Elders, experiencing village life and nature, and being exposed to anti-drug messages and resiliency skills were the focus of COS from the beginning. All these goals are difficult to accomplish in a urban area like San Francisco.

A summer camp for youth commenced in the first year of Phase I. Approximately 140 youth attended the first four-day camp. Held outside the confines of the urban setting, the camp offered classes that addressed Native identity, urban survival skills, traditional dancing, drumming, and how to remain Indian and succeed in the modern world. COS recruited volunteers from the community, elicited donations, and advertised widely concerning the camp. Year two experienced a slight increase in attendance. Coordination difficulties, security concerns, and support services such as food, shelter, and transportation consumed the energies of the staff. These first two years were judged quite successful.

Phase II witnessed an explosion in attendance and the creation of new challenges, one of which was the budget issue. The first Phase II youth campout had over 400 participants, and cost projections were significantly less than the actual cost. The director had to shift cost centers within the grant to cover the

expenses, impacting subsequent years for the camp and decreasing the available funds for other projects. The next year saw an equally great turnout. Reputation and word-of-mouth advertising propelled the camp into the central Healthy Nations namesake event. The effort and resources to coordinate this four-day camp taxed the staff and stretched the collaboration and volunteer networks. Success was not just measured by the youth attending but included the level of volunteerism and range of donations from the community.

The story of a recent graduate from the residential treatment center defined the attainment of multiple grant components and the measure of success Healthy Nations enjoyed. Although not professionally skilled, he felt compelled to share his hope and recovery and give back to the community. He volunteered to chop wood for the camp sweat lodges. For four years, this man provided wood for the fires, allowing the youth to spend the maximum time with the counselors, teachers, and Elders. He joined with them through work, by demonstrating the community and traditional ways, and by exemplifying the spiritual roots of being Native. The informal mentoring and meaningful services impacted many youth and helped the person to maintain his sobriety.

Other Native community members donated bottled water, transportation, and food services. Friendship House staff and aftercare clients cooked traditional meals for the youth. Other consortium members provided supervision, counseling, and gifts. Older youth mentored younger kids. Elders shared with adolescents without fear. Assembling the traditional village provided connection, identity, and ownership to the youth. The impact was the realization of common

beliefs among disparate youth groups, the discovery of a positive Native identity, an increasing sense of worth gained through completion of tasks, and participation in creative functions. The staff and camp volunteers believed that these experiences would decrease the problems in the lives of these youth. The attractiveness and importance of this camp is reflected by the continuing requests for Healthy Nations information and inquiries concerning volunteering. Now, three years after the last camp, youth, family members, and referral sources call to see if at-risk Native youth can participate in the camp.

The founding philosophy of tradition and culture was gradually infused into aftercare and treatment through the mobilization of the COS Healthy Nations project. Development of sweat lodge ceremonies at the three participating residential treatment facilities, inclusion of more Native spirituality and messages into the treatment interventions, and use of traditional activities as alternatives to destructive behaviors confirmed the importance of the Healthy Nations project. The idea of creating a macro-tribal identity from the diverse and diffused factions of American Indian peoples through camps and organized gatherings produced a foundation for addressing cultural powers in healing the substance abuse wound.

Although the agency consortium fractured and did not function smoothly or well over the course of COS, the initial discussions and visioning together stimulated a refocusing on culture and recognition of traditional strengths in the prevention of the social ill undermining youth and Native communities. These messages of identity, pride, and power filled the public awareness campaign. It is

reported that these ideas infiltrated other grant proposals and enriched agency structures.

The clearinghouse ideas, though proving too expensive and cumbersome, demonstrated an essential barrier to raising the health status of this population. With over thirty Indian agencies, the Bay area is rich in resources, but weak in coordination and communication. The system was compartmental, reflecting the nature of the funding and the circumscribed piece of wellness that they targeted. Access and gathering information was burdensome and confusing to many services seekers. The goal of coordinating with shared vision and effort through Healthy Nations was a perfect solution to the resource confusion. Sadly, money was a barrier.

Another reality was the politics and mission of each agency. Having a multi-year grant of close to a million dollars as unique in scope and intention as Healthy Nations did not detract from promotion of ongoing projects or filling agency gaps. The collapse of the consortium and the effort to better facilitate referral and information punctuated that ambitious and ideal nature of the Healthy Nations COS project. Even with a single agency management and direction structure, the philosophy of collaboration flatly refused to concede to failure.

Communications proved difficult across agencies. The early structure of information dissemination from RWJ through the NPO to the director or consortium representative appeared to narrow the depth of understanding and set up fears of dilution and selective information sharing from the other consortium members. The expectations of the grant were interpreted differently

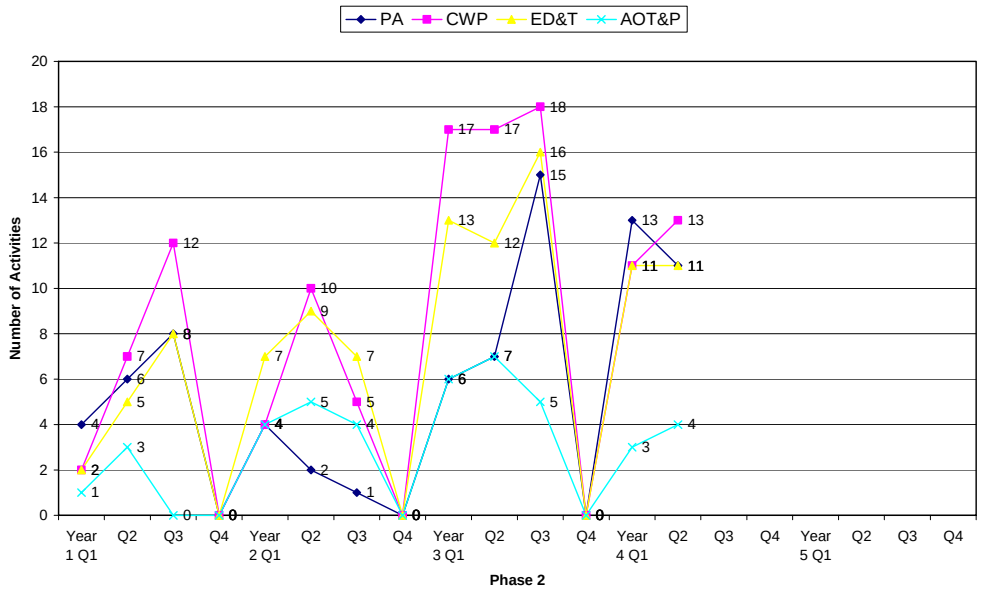
by each participating agency, leading to diffusion of the vision. A closed-loop system inherent in the structure and management of the grant led one early participant to indict such a system as partially responsible for the falling away of other members. The collective nature and hope of Circle of Strength fell victim to perceived centralization under different leaders, exacerbated by the information transfer channels. Relationships early in Phase I with the NPO and RWJ were described as production- and deadline-oriented.

Unfamiliar with the freedom afforded by this grant, different Healthy Nations coalition members became suspicious about being left out of the money allocation. The lack of the usual grant prescriptions, combined with the open philosophy of the Healthy Nations project, contributed to the comfortable and competitive retreat previously existing between the original consortium members. Over the course of Circle of Strength Healthy Nations, some of the original agencies found a way of sharing, especially those with treatment components. Efforts to reach out to earlier members faded with time, and efforts were made to address the objectives and needs of the identified populations.

The Circle of Strength Healthy Nations project in San Francisco progressively reached out to the community through public awareness and culture-based prevention activities, while incorporating more traditional and spiritual healing into treatment and aftercare. The high hope of coalescing thirty agencies in a common vision and effort devolved into a related few agencies shouldering the load and advancing the philosophy and mission of Healthy Nations. Successes were registered in youth prevention and incorporation of

traditional activities into treatment. The ideas and ideals of COS Healthy Nations remain vibrant and active even today. Although most programming ceased when the funding ended, individuals and small community groups carry forward the message of traditional pride and identity. The hope of easier access and simplified information gathering and referral remained central some three years post termination of the RWJ grant.

Friendship House Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Northwest New Mexico

Gallup, New Mexico

Healthy Nations Program

July 1997 – July 2000

“Tag Team Prevention: From Fighting Back to Healthy Nations”

Northwest New Mexico Narrative

Historical Context:

The Northwest New Mexico Fighting Back Healthy Nations (FBHN) Initiative served the greater McKinley County area as well as parts of Cibola and San Juan counties in northwestern New Mexico. An area of approximately 15,144 square miles of high desert, this region is larger than Maryland and Delaware combined. Supporting the largest concentration of localized Native American populations in the United States, the cultural diversity and geography of this catchment region posed challenges and opportunity for the Healthy Nations program. Six different Native languages are spoken among the four Native American Nations—Zuni, Laguna, Acoma, and Navajo. The Navajo Nation, which is the largest Native American group, and the Pueblo of Zuni, one of the most isolated Native groups, combined with the strong Hispanic culture create a diverse cultural mixture demanding expert coordination and negotiation skills.

Each Nation, as well as their individual communities, offers different services, presides over different jurisdictions, and interacts with multiple federal and state agencies. No centralized governmental system or representative body acts as a voice or legislative quorum for all groups and communities. This poses a significant challenge to organizing and executing a broad prevention and social change initiative. For decades efforts to build coalitions have met with varied degrees of success. Competing needs, different philosophies, and historical

tensions have created numerous systems of services, intersecting many times only under duress and forced necessity.

Known in the late 1980s as the “Drunk City,” Gallup—the largest metropolitan center and hub of activity for this region—reported alcohol-related deaths at three times that of the surrounding state and six times that of the United States. Numerous surveys and research projects confirmed the negative depiction and unacceptable statistics. Many indicators demonstrated the dire circumstances existing in this region. Reservation poverty levels reached the 75 percent level. In McKinley County inadequate financial resources addressing public intoxication compounded the growing human cost. Northwest New Mexico was suffering an alcohol-related social blight, unknown elsewhere in the United States. Student surveys at the time outlined the usual indicators of negative outcomes: 67 percent of youth under 21 dropped out of school; 63 percent considered themselves chronic substance abusers; 84 percent used substances during their twelfth grade of high school; and of those reporting, 61 percent of twelfth graders believed alcohol and drugs were major problems at school (County Alcohol Problem Indicators, NIAAA and Kid Counts).

This tri-county area, home to 11 percent of New Mexico’s population, was also overrepresented on other negative statewide social indicators such as murder (14%), fatal crashes (22%), alcohol-related deaths (20%), and alcohol-related crimes (24%). These statistics, as cited in their proposal and numerous other sources, indicated use of alcohol and substances as a leading cause of social decline and human problems. In response to growing concern and

increasing negative impact on the communities, a coalition of governments—including tribal organizations and private citizens—commissioned a needs assessment and strategic plan to deal with the problem of alcohol and drug misuse.

With the impetus to change their reputation, leaders and citizens of Gallup as well as other governments, including those from the Native American Nations, began dialogues and public meetings to muster forces to stem the tide of destruction caused by alcohol and drugs. A confluence of events, some positive and some tragic, initiated the creation of the context within which Healthy Nations grew. In 1987, in response to growing concern about the treatment of the public inebriates and the use of "drunk tanks," a committee was formed to investigate more humane treatment for these chronic substance users. In 1988 the Gallup City Council resolved to support a closure of drive-up window liquor sales and to initiate an optional local excise tax on alcohol. This started a counter movement by the strong liquor lobby and proprietors resulting in tension that was present until 1992, at times interrupting the progress of the change.

The Council of Governments, a group commissioned by Gallup's mayor, continued to hold public meetings to address the alcohol problem. Public attention as well as state government awareness followed a six-part series in the *Albuquerque Tribune*, "Gallup: The Town Drunk." Other reports followed from national and state sources. The lid was off the secret of one of the worst alcohol problems in America.

In early 1989, a galvanizing event happened when a drunk driving incident took the life of three-month-old Jovita. In response, the mayor and local leaders planned and launched a 200-mile walk to the capital to garner support to legislate and address the spate of tragedies and social costs in the region. One hundred and fifty people began the twenty-mile-a-day trek, reaching the steps of the Capital seventeen days later as a throng of 2,000. The political outcome was a referendum for McKinley County to place excise taxes on liquor, laws to shut drive-up window sales of liquor, and a U.S. Congressional appropriation for a new alcohol crisis facility—Na'nizhoozhi Center. In 1990 the excise taxes were implemented, a regional alcohol summit was held, and Northwest New Mexico received one of fourteen planning grants from the Robert Wood Johnson Foundation, entitled "Fighting Back."

Fighting Back was a RWJF grant released to support mostly intercity areas addressing substance-related issues. New Mexico was the only rural recipient of the fourteen original Fighting Back sites. (Much has been published concerning this program. I refer the reader to such sources, especially those on the RWJF website). The Healthy Nations Initiative followed and built on Fighting Back.

In 1992 the Northwest New Mexico Fighting Back initiative was funded for 3 million dollars over five years. Focusing on community mobilization, public information awareness, and the provision of technical support to diverse community groups and organizations, Fighting Back established itself as an unbiased resource to address the alcohol problem in varied venues. It offered

support for the new alcohol crisis center, organized leadership summits and work sessions to brainstorm solutions, and advocated and lent support for governmental changes, including the excise tax and sales limitation on alcohol. In short, Fighting Back was the forum and moderator of the growing public conversation about alcohol problems.

Fighting Back helped to change the course of McKinley County and offered resources and support to those struggling, either personally or politically, with alcohol- and drug-related issues. The statistics are impressive and convincing. (Please refer to the publication: “The Latest View” copyrighted in 1999.)

In 1997 as the funding for Fighting Back was closing out, the Healthy Nations Initiative—a more targeted Native American substance abuse grant from Robert Wood Johnson—was just beginning Phase II Implementation at thirteen sites across the United States. The Fighting Back staff and representatives of Robert Wood Johnson felt that transitioning this successful program into the Healthy Nations family would solidify the gains and extend the positive aspects of the existing program. By invitation, Fighting Back prepared and submitted a Phase II Implementation proposal.

Phase I:

New Mexico did not participate in the Healthy Nations Phase I process. It was actively involved with the Fighting Back Initiative from Robert Wood Johnson Foundation. The HNI Phase I intention of planning and development of strategies

to address substance abuse in Native American communities had been satisfied by the five years of Fighting Back. The structures, processes, and activities of Fighting Back more than adequately served to delineate the problems, generate partial solutions, and mobilize coalitions of concerned groups and individuals. The groundwork for Healthy Nations was well-established. The NPO and NAC all concluded that inclusion of New Mexico was in the best interest of the overall project. The proposal was accepted and Northwest New Mexico Fighting Back became a member of Healthy Nations.

Transition:

The transition from Fighting Back to Healthy Nations required tribal sanction and governance but was rather seamless. The executive director of Fighting Back left her post at the end of funding, and the director of Na'nizoozhi Center, an active member of Fighting Back, became the executive director of the nonprofit Northwest New Mexico Fighting Back, Inc. With support from the partner agencies and coalitions of governmental and private leaders, he moved systematically to extend the life of Fighting Back with Healthy Nations funds. The shift in both staff and philosophy was minimal and consisted of minor adjustments.

Healthy Nations exhibited more structured programming components that addressed substance abuse, and it encouraged more individual and direct community support. The RWJ grant components were adequately addressed in the Fighting Back Healthy Nations (FBHN) proposal. All other difficulties

experienced by Healthy Nations sites, such as reporting and financial accounting, had previously been resolved, leaving the staff to act in the identified communities. FBHN took its place among the thirteen other sites in stride and with little disruption in the trajectory of the previous five years.

Phase II:

Fighting Back planned to participate in the communities in a more intense and specific manner. The structure of the FBHN was to have coordinators in each of six communities. These communities—Shiprock, Counselor, Crownpoint, Acoma, Laguna and Tohatchi—represented population centers from the three Native American nations. These coordinators worked with the local governments, leaders, Elders, and organizations in garnering support for prevention and public awareness activities. The process was to utilize local community action teams in strengthening local ownership and empowering the community to act against the problems created by substance abuse. Listening and coalition-building were the main requirements for the coordinators. Each needed to demonstrate the ability to bring together and balance the different needs and interests as well as mobilize the community.

During the first year, Crownpoint, experienced the only change in personnel created from these requirements. Another coordinator, well-known to the community, was quickly appointed by the community and maintained the objectives with no discernable delay. Acoma was deliberate in appointing a coordinator. In maintaining the self-directed philosophy of the community

listening model, the leadership of Acoma pondered the qualifications and “fit” of the coordinator and made its choice toward the end of year one. An anticipated change in personnel happened in 1998 when the assistant director from Fighting Back transitioned to another position outside Healthy Nations. However, this person remained active in the Fighting Back programs through voluntary support. No other personnel changes occurred in the execution of Phase II.

Since specific community help had not been the mainstay of Fighting Back, the first year of Healthy Nations was focused on creating a mechanism to hear the community members and mobilize their resources. Community meetings, participation in community council meetings, and direct solicitation of feedback from community members became the method of listening and planning. Other early efforts included bringing in Boy and Girls Clubs as alternative activities to substance use. This objective was successfully realized in two communities. Coordinators facilitated public awareness campaigns by offering technical support, materials and ideas for posters, staffing at booths for community gatherings, and leadership and skills trainings. The staff at the Na’nizoozih Center served as focal point for technical support, helping to train the coordinators in using laptop computers and inspiring cultural and traditional treatment and aftercare alternatives. The first year was one of discovery and the initiation of locally staffed action teams. The response was positive and the energy and power of Fighting Back grew.

As the coordinators gained experience and were faced with demands and opportunities, the need to have Healthy Nations support was apparent. The

director organized bi-weekly meetings so the coordinators could share ideas and concerns, gain support, and cross-train. The demands of the catchment area made the efforts to gather together all the more challenging. Having to drive long distances on less-than-ideal roadways placed a burden on the staff. Compensation and accommodations of travel demands necessitated a budget revision that met with little comment from the NPO.

In the second year, the National Program Office held a site visit. Stimulated, in part, by concerns about reporting requirements which included increased specifics on the reports, the tenor of the site visit was supportive and demonstrated a genuine concern from the national office about Fighting Back. This went a long way toward bolstering the program and, combined with participation at the grantee meetings by some of the coordinators, solidified Fighting Back's place in the family of Healthy Nations.

The exchange of ideas and technical assistance grew between other sites and Fighting Back. Although the incorporation of such ideas was not readily apparent, the overarching philosophy of listening to the communities and the universal experience of other Healthy Nations sites in the political arenas helped this program blossom.

Toward the end of the funding of Healthy Nations, Fighting Back had successfully institutionalized many of their activities. The requirement to garner community support including material resources and personal commitments had borne fruit. For example, communities established and sponsored Boys and Girls Clubs. The Joey Harry Memorial Run and The Red Ribbon Multicultural Relay

Run, involving hundreds in the Shiprock area, are now sponsored by the local government and organizations. The Counselor coordinator assisted the community to petition to close three liquor establishments. Two of the outlets were closed and the third was under pressure from members of the local community and state agencies. Acoma had mobilized the community to exert pressure on Wal-Mart to severely restrict alcohol sales. Wal-Mart responded to the community by significantly limiting liquor access. Crownpoint organized a network of providers and service agencies to address alcohol-related issues such as domestic violence. The community and local organizations now sponsor youth sporting activities, and they regularly petition local authorities to limit the availability of alcohol and other substances.

Coalition building and the transfer of responsibility and sponsorship of prevention and public awareness to community authorities and members highlighted the last year of Healthy Nations. The Na'nizhoozhi Center maintained a strong relationship with state and local governments, expanding their services and gaining further funding through grants and legislative appropriations. The Center established itself as a source of traditional and cultural programming. The philosophy and activities of the Center have been copied and instituted throughout the national treatment network, and prevention and public awareness have carried the message embraced by the Center and staff.

The Healthy Nations communities created avenues for returning Center clients. They carried the spirit and healing philosophy, further strengthening the impact of Fighting Back. The original Fighting Back and community initiative to

tax the sale of alcohol and funnel the money into prevention and services has routinely been supported by voter approval nearly five-to-one. This formed a foundation for sustainability for the Center and, therefore, the spirit of Fighting Back.

Personnel and associated individuals remain an asset in the region. The Counselor coordinator was elected to the position of community (chapter) president. The project secretary was hired by the state as a prevention specialist, and the other coordinators remain in their communities helping to heal the damage of substance abuse. Ideas and activities became institutional. The Acoma Healthy Nations programs were folded into their new Drug Elimination program, while Tohatchi spun off three nonprofit organizations initially sponsored and supported by Healthy Nations. The reach of Fighting Back and the extension afforded through Healthy Nations proved the recipe for success and change.

Highlights:

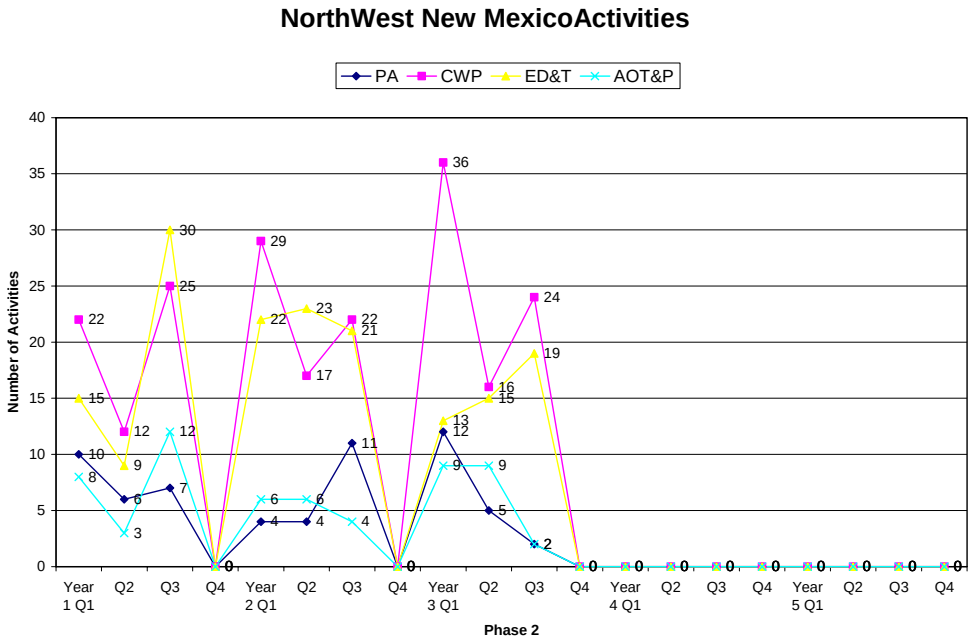
Many positive things grew from Healthy Nations on the successes of Fighting Back. The longevity of the combined program as well as the stable leadership and strong coalitions made this program site successful. One project that supports this is the New Year's Eve dance, now in its tenth year. Sponsored as an alternative to other dangerous and drunken parties, Fighting Back set out to change the face of New Year's Eve. The efforts of Healthy Nations in promoting sobriety and in energizing the communities through school curricula, youth sport activities, and open public dialogue has forced this activity to larger

and larger venues due to overwhelming response. From humble beginnings with about a hundred people to the current nearly 900 participants, this sober and wellness event epitomizes the Healthy Nations intent.

Public awareness and action have resulted in clear and measurable outcomes. One such project was getting the department of transportation and tribal governments to petition for widening and illuminating a stretch of road better known as the “death strip.” With persistence and Healthy Nations support activating the coalitions and organizations, this was finally accomplished resulting in a significant decline in deaths along this stretch of freeway. Combined with the referendums to tax the sale of alcohol, close Gallup’s drive-through-window liquor sales, and petitions closing bars and liquor establishments in many communities, the long history of Fighting Back has produced results that have created a better now and brighter future for those living in this region.

Personnel continue to be an asset that remains viable and active. The director and coordinators are all still active (2003) in the communities and the political arena. Chapter presidents, state commission leaders, coordinators of youth programs, clinical staff, and coalition facilitators are just a few of the positions currently held by those taught and supported by Healthy Nations. The philosophy of listening is still the standard. Limited funds and the period of funding restricted the number of communities that were able to be served and would have benefited from Fighting Back Healthy Nations. The number of volunteers and leaders who gathered to support activities, participate in trainings,

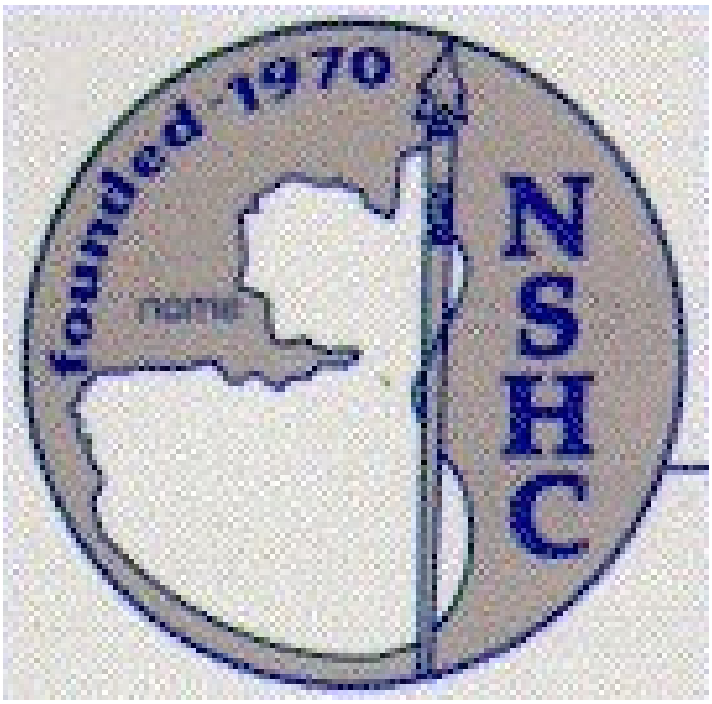
and petition the government rose in a timely manner and continue to promote change and offer hope.



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Norton Sound Health Corporation

Nome, Alaska



Healthy Nations Program

December 1993 – November 2000

“Growing Individuals and Communities at the Artic Circle”

Norton Sound Health Corporation Narrative

Historical Context:

The Norton Sound Healthy Nations project was the farthest north of all grantees, located in Nome, Alaska. Nome is poised on the tip of the Seward Peninsula, some 560 air miles north of Anchorage—accessible only by air travel. A unique and varied topography defines the communities, cultures, and services provision structures within the region. Covering some 44,000 square miles, this combination of treeless tundra, rugged mountain coasts, and islands in the Bering Sea is home to roughly 10,000 residents. The population centers are fifteen established villages and two seasonal campsites—home to twenty distinct groupings of people. The weather also defines the region and life therein. Severe winters often disrupt the required small plane travel (there is one village to which there is a passable road). Ice and snow routinely challenge communications, travel, and services. Long winter darkness and manic summer midnight sun define activity levels as well as availability and access to target populations.

The combination of geography and weather pose a challenging scenario to provide services in the region. The area is the crossroads of three Native Alaskan groups: the Inupiaq, Central Yupik, and Siberian Yupik. These three major language groups are dispersed throughout the region. This confluence of different ethnic groups presents a history of tension, shifting political alliances, and remarkably diverse cultural behaviors.

Nome, the largest city in the area, is the regional hub. Most cash-based economies, health and social services, and federal and state programs operate from Nome. Known as the “white man’s town,” Nome is famous for the gold rush and romanticized frontier mentality of the turn of the twentieth century. It is the terminus of the Iditarod sled dog race. Nome, a community of 3,500 residents, is the home of the Norton Sound Health Corporation (NSHC). The largest employer in the region, NSHC provides a continuum of health services including medical and emergency services, medical itineration and community health aids, and mental health outpatient and substance abuse inpatient programs. Public health nursing, pre-maternal residential care, and health education make up some of the different services. NSHC exists under charter from the fifteen representative villages. Each village is a second-class city under Alaska statute with a city council government. Correspondingly, each village is an incorporated Native corporation with an attendant tribal council or Indian Reorganization Act government. NSHC is the collective health arm of the villages and is a nonprofit corporation currently functioning as a public law 638 entity.

The region has long been under the siege of alcohol abuse and related problems. Most of the villages are considered dry except for the porous, illegal importation of alcohol and drugs. Nome is notably a wet town. Thirteen bars line the famed Front Street, and daily demonstrations of the extent of alcohol abuse are witnessed on this central artery of Nome. Although limited systematic surveys have been conducted, common knowledge and observation document the severity of the damage. The resistance to being surveyed takes many forms.

Principally, the lack of anonymity in the very small communities or fears that the survey would underestimate the real problem has conspired to silence the data. Some indicators that support the acknowledgement of problems with substances came from a 1991 student survey. Sixth through twelfth graders responded to questions about inhalant abuse, revealing a 48 percent lifetime prevalence and a current-year rate of 11 percent.

A 1990 review of court documents showed an 81 percent rate of alcohol involvement in the crimes brought before the bench. A random sample of police logs from 1993 indicated that 43 percent of all calls were related to alcohol. The Nome ambulance calls revealed that a majority of responses involved alcohol contrasted with the NSHC emergency indications that a mere 11 percent of emergencies treated had a primary or secondary alcohol diagnosis. The Bering Strait Women's Group, a nonprofit organization dealing with battered women, estimated that over 50 percent of all domestic violence and sexual assaults attended to by their agency were alcohol related. The region is identified as exceeding the national and state levels of suicide. Substance abuse is cited as a pre-disposing factor in the disproportionate level of incarceration of Native males. Further evidence substantiating the endemic nature of substance abuse is that there existed sixty agencies and programs addressing alcohol and substance abuse at the time of the Robert Wood Johnson Foundation Healthy Nations project call for proposal.

The Interagency Child Advocates of Norton Sound formed following a meeting in 1988. Native and non-Native programs, state agencies, and volunteer

groups convened to address social needs and program gaps including substance abuse. Over a period of three years, this group evolved into the Bering Strait Community Partnership. Early in 1991, the Bering Strait Community Partnership successfully competed for a demonstration grant from the Center Substance Abuse Prevention (CSAP) agency. This event defined the context of the next five years in addressing substance abuse. Also, in 1988, Nome community members formed “DAWN,” an acronym for “drugs aren’t wanted in Nome.” They sponsored youth activities, lobbied for tougher laws against distribution to minors, and supported the national “red ribbon week.” The following year (1989), a region-wide Elders’ conference passed resolutions calling on the community leadership and Native service agencies to enhance local resources to combat the devastation caused by substance abuse.

In 1991, NSHC hosted the first Inhalant Abuse Conference, bringing together state leaders and key stakeholders. That same year, the Bering Strait Community Partnership received the notice of award for the substance abuse prevention grant. In 1992, NSHC sponsored a Fetal Alcohol Syndrome Education Conference targeting local community members and service providers about the related issues. Concomitantly, Kawerak—the social service sister Native Corporation to NSHC—obtained a grant to help the villages address the growing problems of pregnancy and drinking. It focused on developing local ordinances to encourage traditional and local interventions concerning substance abuse, particularly pregnant women’s substance abuse. Simultaneously, community visioning workshops were being held across the region. These workshops

attempted to identify needs, set goals, and establish coordination of resources. In the third year of visioning, the RWJ call for proposals was released.

Phase I:

The Bering Strait Community Partnership (BSCP) had carved out an important niche in the landscape of providers. Originally considered a small, harmless group of non-Native caregivers, the grant award changed their community stature. The 2.5 million dollar infusion into the community garnered the attention of the larger Native corporations. Previously disinterestedly supportive of the Partnership, the award incited withdrawal from and elicited resistance to contributing to the goals and purposes of the Partnership project. The rationale for the conflict cited lack of listening and responding to village needs in the proposal development. This tension clarified a long-standing inside/outside dynamic based on Nome-centered service provision and villages just receiving the program developed for them. Kawerak soon sided with NSHC in boycotting the Partnership project. Both sides counterclaimed that the other had been insensitive and deaf to the voice of the village.

In response to the tension, the BSCP established a steering committee made up of village representatives and other Nome agencies. This committee concentrated on helping the villages express their ideas, garner state development grants, and hire outreach coordinators. Resolution and cooperation were slow to emerge. One of the significant factors was a change in personnel at the Partnership. The original director left the position, and the new director, a

known community member, adopted a reconciliatory stance and convened a project reorganization meeting. The outgrowth of this effort was the joint agency creation of an oversight committee, the Substance Abuse Prevention Programs Committee. This committee negotiated the interagency relationships throughout the duration of the CSAP grant while acting as the advisory committee to the Healthy Nations proposal and Phase I programming.

A successful proposal through the Norton Sound Health Corporation landed the Healthy Nations Phase I development and planning grant. A coordinator was hired. She had experience with other NSHC programs and was well-connected to the corporation administration and greater community.

Early in proposal development, a group of 25 agency members and village representatives gathered to identify gaps in services and to address the four components of the Healthy Nations grant. The outcome was the formulation of goals and objectives to meet the community needs and address the grant requirements. Public awareness and community prevention topped the activities lists. The mission and vision of Healthy Nations was developed. A logo, somewhat detached from the mission, was developed. Pilot programs were undertaken in two outlying villages to enhance local human and information resources.

The parallel nature and target of Healthy Nations and the Partnership Project facilitated some early development of goals while concurrently limiting the Healthy Nation’s identity and unique mission evolution. The old tensions, the sharing of the advisory committee, and the target of substance abuse prevention

confused early Healthy Nations efforts from the status quo. The intent of NSHC was to collaborate with the other program and create a unique presence in the region. The director attended interagency meetings, sought training outside, and relied on previous supervisors as the program unfolded. Great effort was exerted in community awareness and information dissemination carrying the name of Healthy Nations. Outreach successfully canvassed the whole region. Healthy Nations was attempting to create an individual reputation and relationship with the villages. This was interpreted by some as obstructionistic to the Partnership project; others saw it as differences in leadership style and director uncertainty, while yet others attributed it to remnants of the historical tensions. Whatever the reason, the actions to distinguish Healthy Nations from the Partnership project proved fortuitous and prophetic.

Phase I activities included media events targeting health issues, creation of resource networks, and collaboration with preexisting substance abuse programming activities. Recruitment of village-based volunteers consumed much of the coordinator's energies. Overwhelmed with travel to villages and outside trainings, learning administrative concerns, and attending or conducting meetings, the coordinator left some objectives undone. Others were significantly reduced in scope.

Office space played a role in the early development and trajectory of Healthy Nations. The first office was centrally located by other agencies outside Norton Sound. This initially helped define the influence and connection with other agencies. Toward the end of Phase I, the offices were moved to the Northern

Lights Recovery Center, the NSHC inpatient substance abuse treatment facility. This move influenced intra-agency coordination and shaped a service-oriented model. The early intervention and aftercare component of the grant was to have been easier to address through this relocation. This move did little to support the emerging identity of Healthy Nations or transcend the insider/outsider tension. Administrative oversight was located under the management of the Northern Lights Recovery Center, an arrangement which was insufficient for the needs of the grant. Changes in the Center's directorship, pressing treatment demands, and the lack of upper corporate administrative oversight hindered the grant's growth and compliance and set the stage for challenges in Phase II.

Preparation of the Phase II proposal expanding on the goals and objectives of Phase I dramatically reduced the number of initially anticipated activities. Certain grant component areas had been neglected and others proved very difficult. The planning and development phase had demonstrated some barriers and experienced internal adjustments not conceived in the original proposal. The transition to implementation and the establishment of Healthy Nations as an integral part of the region was entering a rough but defining time.

Transition:

Many inside and outside factors converged during the transition to Phase II. The resulting changes and instability evolved into long-term positives. The original coordinator had announced her intention to earn a graduate degree, and at the crossroads into Phase II, she left. The next coordinator assumed the

responsibilities without the benefit of having prepared the proposal and understanding the philosophy. Newer to the field of prevention, she brought educational experience and a less-established community presence.

At the same time, the Norton Sound Health Corporation underwent changes. Still without a vice president of Behavioral Health, the director of Northern Lights was acting as liaison to the corporation. Significant staff turnover and the ongoing void in administrative oversight led to poorly defined roles and goals. Likewise, the ending of the Partnership project created a gap that the new Healthy Nations was expected to fill. Shuffling of NSHC departments and corporate responsibilities also punctuated this period. Increasing demand for village-based resources, budget concerns, growing distance from the advisory committee, and different view of the etiology of substance abuse defined the context of the transition. Demands for the resources of the grant, incomplete understanding of the grant reporting requirements, and the lack of Healthy Nations staff compounded the instability and vacillating nature of the program. The first director had responded the best that she could but the changing structure around her negatively impacted the overall success. Notwithstanding the chaos at the transition, the seed of the future program had been planted, and the pilot programs in the two villages were evolving.

Phase II:

Healthy Nations was administratively relocated to the Community Wellness Program (CWP). This addition to the NSHC health education efforts

seemed a perfect match. The first months of Phase II saw a reorganization of the priorities and staffing of Healthy Nations. Finally, a vice president of Behavioral Health was hired, who was supportive of the Healthy Nations goals and of the new coordinator.

Early in 1997, the NPO had a site visit to address documentation irregularities and general noncompliance with grant requirements. This meeting was the inaugural experience for both the new HNI coordinator and the Behavioral Health vice president. The intensity of the meeting and the possible dire consequences got the attention of the upper NSHC administration. After quick negotiations and promises, the Healthy Nations funding was safe and more centrally located in the vision of the corporation.

A series of strategic planning meetings with the staff of CWP/HNI articulated and expanded the goals of the Healthy Nations proposal. Capitalizing on the successes in village outreach and the placement of Suicide Prevention Specialists in three villages, Healthy Nations again focused on increasing village-based resources. The Healthy Nations staff constructed a “train the trainer” model working in concert with state, NSHC, and Kawerak personnel. The goal was to train village personnel, leaders, and volunteers in prevention skills while helping to develop natural leaders. As workshops and community meetings were held, the Healthy Nations staff learned that volunteerism is difficult in economically depressed villages. Compensation as well as material provision became apparent. This increased participation and follow through. Healthy Nations forged village and agency partnerships; provided trainings, materials,

and information; and managed a village incentive grant program through the CWP. Being more closely situated and connected to the Behavioral Health Department offered cross-fertilization of programs, especially the long-awaited Village Based Counseling project. Again, at a vulnerable point, staff changes disrupted the flow. The sudden resignation of the vice president coupled with the loss of another Healthy Nations staff person created a pause in support and consistency. This would not be the last leadership change.

A new director of Behavioral Health Services (BHS), taking the role of the former vice president of BHS, was promoted from within. An outsider from the Lower 48, this psychologist initially set standards seemingly at odds with the ongoing Healthy Nations posture and model. He pressed forward with completing the Village Based Counseling program, ultimately covering fourteen of fifteen villages. His interaction with the Healthy Nations staff was cordial, but strained. Conflict in resource allocation underscored much of the tension. The perception of Healthy Nations being a stand-alone entity in the blueprint of integrated services espoused by the director interrupted completion of some goals and diminished other activities. Each party struggled to incorporate the worldview and philosophy of the other. This strain resolved over the next year.

The Healthy Nations programs in the villages, especially the Suicide Prevention Specialists, informed the design and implementation of the Village Based Counseling structure. This convergence of village-based models solidified the administrative partnership within the Behavioral Health Services unit. The Health Nations staff and the Suicide Prevention Specialists helped train and

support the new Village Based Counselor trainees. The Healthy Nations focus on local ability and understanding was an important contributor to the decentralization movement undertaken in the Behavioral Health Services unit. The director espoused a public health model and advocated greater inclusion of tradition and culture. The confluence of the positives of Healthy Nations and the shift in direction and infrastructure of the whole BHS unit blurred the lines between doing activities toward Healthy Nations goal obtainment and institutionalizing the philosophy of prevention and local ownership.

It was at this junction that the Healthy Nations coordinator and program manager left to assume other administrative jobs in the community. Integration and budget cuts reassigned the other staff members, and Healthy Nations was absorbed into the infrastructure of the Behavioral Health Services unit. Luckily, the first coordinator returned from graduate school in New Mexico, worked in the BHS administrative office, and re-engaged in husbanding the grant. This period defined the decentralization effort.

Village-based programming, greater collaboration, and recognition of the strength of indigenous knowledge were hallmark of the regional prevention and intervention model. Doing “with” the village instead of doing “to” the village was now the philosophy. Healthy Nations supported the Village Based Counseling training through the University extension Northwest campus in Nome. Healthy Nations funds supported rewriting the job descriptions for all service providers to include prevention and public awareness responsibilities. BHS transformed the inpatient services into an intensive outpatient program, incorporating the village

personnel in the early intervention and aftercare service models. Prevention responsibilities for all providers were increased; public awareness became an expectation. More cultural components and knowledge were added in both planning and delivery.

The last years of the grant saw expansion of the first vision of the steering committee. Then a leadership change occurred as the no-cost extension was emerging. The coordinator took an administrative position at Kawerak, complementing the previous coordinator's new vice-president status. The no-cost extension period of Healthy Nations was under the direct supervision of the BHS director. Activities continued to support the Village Based Counselors, inform new programs, and gather and make accessible all resources materials.

Finally, Healthy Nations concluded their formal existence with a region-wide healing conference featuring healthy Native role models and workshops to carry forward hope and progress. Over 600 people, representing all of the villages and Nome, attended.

Highlights:

Early focus on drug-free events and local ordinances supporting healthy lifestyles resulted in significant changes in the environment and the non-acceptance of drunken behaviors. Both the major Native corporations instituted employee drug testing even for their respective boards of directors. Corporate parties and meetings were now drug free (including tobacco). Gatherings in the communities were advertised as substance free, and the attitude toward "using"

became less normative. The evolution of this anti-drug awareness supported local ordinances that had begun increasing interventions and community actions regarding alcohol-related problems.

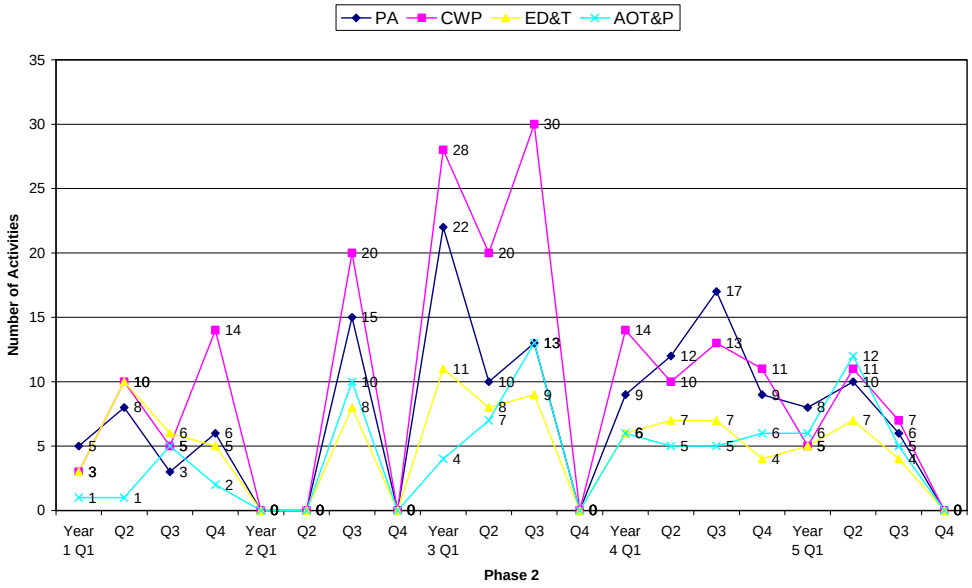
By attending to the wisdom and strength of the villages, NSHC and BHS administration made significant changes in numerous services programs informed by such local insight. Partnership with the villages became central. The creation of networks within the individual communities empowered natural leaders and community members to address otherwise taboo subjects. It helped break the silence around many secrets and wounds. The voice of the village helped form the type and frequency of services. The Village Based Counseling program and another grant program, entitled the Mobil Adolescent Treatment Team, were strongly influenced by Healthy Nations. Having local personnel shape service delivery in the villages shattered the insider/outsiders tension. The attitude and expectation of equal voices and dialogue infiltrated even upper management and other departments. The flexibility of Healthy Nations and the strength of its philosophy provided support for a transformation of Behavioral Health Services.

The showcase accomplishment was the Village Based Counseling program. While not funded by the grant, the Healthy Nations support, philosophy, and example enhanced its viability and effectiveness. As the grant was ending, seven of the fourteen village counselors received university certificates in the Rural Human Services. Three counselors continue toward their bachelor's and one has obtained a master's degree. They melded together the wisdom of

traditional and indigenous healing with the concepts of western counseling. They provided aftercare support for those returning from treatment. They made referrals and provided case management alongside the itinerant clinicians. They organized community events, talked with the youth, taught parenting classes, and worked with tribal leaders in addressing substance abuse and mental health issues. Three have become supervisors; others have continued to be resources in their communities.

The lasting impact—among staff turnover, regional and interagency conflicts, and failed coalitions—remains with the people associated with Healthy Nations. All staff members continue to institute shared philosophies and models in their respective jobs. Two coordinators who hold upper management positions pursue similar goals and implement Healthy Nations-like models in the region. Outreach staff and trainers continue to provide services to families, communities, and recovering men and women. The Village Based Counselors and Suicide Prevention Specialists live in and serve their communities. Most continue to set the example, provide impetus for small but significant changes in their villages, and disseminate knowledge of healthy lifestyles. Just as important are those families and individuals supported through the activities who are giving back to the communities. They are engaging with the youth, teaching traditional skills, and becoming leaders in local causes and government.

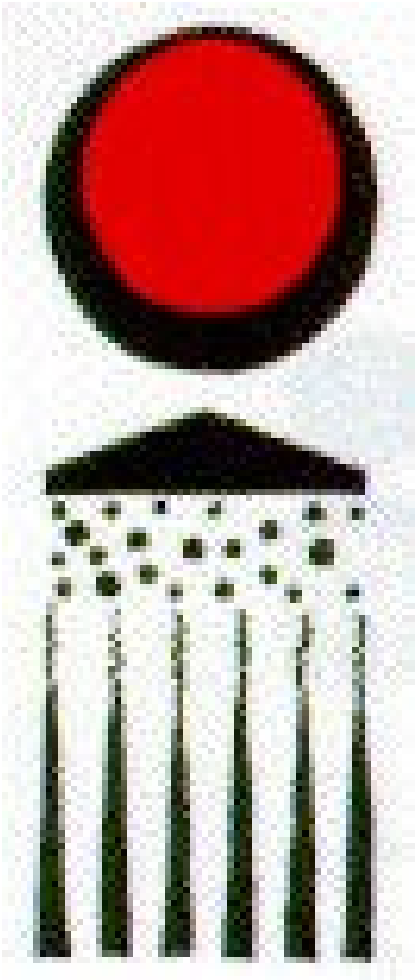
Norton Sound Health Corporation Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Seattle Indian Health Board

Seattle, Washington



Healthy Nations Program

December 1993 – June 2000

“A Variety of Indian Programs Spawned in Urban Communities: From Marches, Computers, and Drama”

Seattle Indian Health Board Narrative

Historical Context:

The Healthy Nations Initiative in the Seattle/Greater King County area of Washington State was originally given to a partnership of two of the larger Indian representative groups—the Seattle Indian Health Board (SIHB) and the United Indians of All Tribes Foundation (UIATF). The SIHB was the recipient of record. This partnership was formally constructed as a cooperative organization in response to the Request for Proposal for the Healthy Nations Initiative of Robert Wood Johnson Foundation. Such a shared arrangement had been suggested by the Healthy Nations National Program Office (NPO) and the National Advisory Committee (NAC). Both organizations had a long history of positive association and relationship in the American Indian communities in Greater King County. Although historically both agencies had worked together in the community, this focused formalization added a level of challenge.

Seattle is home to some 7,300 American Indians and Native Alaskans within a metropolitan area of one-half million citizens. There are no distinct Indian neighborhoods or geographical areas specifically identified as Native. Greater King County includes at least one-fifth of the total American Indian/Native Alaskan population in the State of Washington. Some 20,000 Native residents, among the 1.5 million general population, live within the 90-minute corridor of Seattle. Comprised of members of 252 different tribes from across the United

States, this catchment region is quite diverse and rich, yet it lacks defined cultural structures and regions.

The Seattle Indian Health Board is a multipurpose community health center that was incorporated in 1970. It is a nonprofit center for medical, dental, mental health, chemical dependency, and community prevention education services. Their mission is to raise, to the highest level possible, the physical, mental, spiritual, emotional, and social health of American Indians and Alaska Natives. This is a very comprehensive off-reservation primary care agency with over 150 staff operating at two sites, including an inpatient residential chemical dependency treatment center and a satellite treatment center near Seattle. It provides high-quality care and is accredited by the Joint Commission on Accreditation of Health Care Organizations.

The United Indians of All Tribes Foundation, also formed in 1970, is a private, nonprofit corporation, employing over 100 staff comprised of local tribal leaders and professionals. A majority of the staff is Native American. UIATF is a community and social services-based organization focusing on promoting cultural awareness, social and economic reform, and educational opportunity. It seeks to promote Indian heritage and culture; its goal is to foster and sustain a strong sense of identity and tradition among the Indian people of Seattle. UIATF seeks opportunities to enhance and expand positive change in Native communities, moving toward greater self-sufficiency for Native people.

Well-researched data indicated that a majority of the American Indian/Native Alaskan families in the Greater King County area had been

personally affected by alcohol and substance abuse. Other social indicators showed that American Indian youth in the region faced greater economic challenges, dropped out of school more often, had more accidents, and were more likely to end up in the criminal justice system than their counterpart non-Native peers. Gang violence, drug trafficking, and poverty were disproportionately exhibited.

Phase I:

The successful proposal—The Seattle Healthy Nations: Reducing Substance Abuse among Native Americans—was composed and submitted to RWJF. Following a national search, a director for Phase I was selected from within the UIATF existing staff. The director position was then located in the SIHB administrative structure. The director was to organize and coordinate the Seattle Healthy Nation project and objectives. The central objective of Healthy Nations was the expansion of community outreach programs and services. The identified attitude was one of joining and supporting the community committees and activities that were already established throughout the city.

The selected target populations of the Seattle Healthy Nations were children, adolescents, and their families. Both the public awareness and intervention/aftercare components begun in Phase I addressed this population. The Healthy Nations partnership envisioned UIATF addressing public awareness and community-wide prevention while SIHB focused on the treatment-related components, including early identification, intervention, and aftercare. Such a

natural alignment of each agency's historical strengths and connections within the community seemed logical and efficient.

The first eighteen months were spent primarily conducting focus groups with key stakeholders and agencies representing the diverse and wide range of American Indian culture, concerns, and needs. The Seattle Healthy Nations hoped to bring together a majority of the different tribal members and other community agencies to discuss strategies for addressing substance abuse issues. The agenda aimed to raise awareness of services to help prevent and intervene earlier with substance-related problems. Many of the activities undertaken as part of the four components of Healthy Nations targeted enhancing established efforts and programs. These activities were based on the philosophy of an activity-based versus an educational prevention and support model.

Many meetings and attempts to bring the diverse community committees together under the rubric of a Healthy Nations advisory committee exposed the differences between the two recipient agencies. The Healthy Nations goal of community-wide integration and coordination of successful programs became more obscured due to increased attention toward dissipating the growing tensions in the shared administration of the program. A leadership collapse was precipitated by the pressure of negotiating two different corporate dynamics. Dealing with community-perceived expectations of the project named "Healthy Nations" added to this internal stress. Many community members thought that

Healthy Nations would address all social and medical needs and would bridge all disparities.

Eighteen months into Phase I, the first Healthy Nations director vacated his position. This departure at such a critical time left a void in an essential position and demanded quick action. The situation forced recognition of and negotiations regarding the different governmental structures and fiduciary responsibilities between these two fine agencies. The outgrowth of resulting discussions was the hiring of an SIHB Community Outreach supervisor as the new HNI director, who was hired and introduced during an NPO site visit. Fortunately, the new director had some knowledge of Healthy Nations and had worked in the community prior to this advancement.

The NPO and Robert Wood Johnson Foundation representatives strongly encouraged the new director and the SIHB to fulfill the original proposal objectives. This call for action on Phase I was complicated by the fact that the Phase II implementation proposal was quickly coming due. The director scrambled to respond to the requirements of the grant, build on the Phase I work, and follow the recommendations of the Healthy Nations Advisory Board, NPO, and SIHB.

Transition:

Four iterations of the Seattle Phase II proposals were submitted. The first three were rejected due to concerns over too much emphasis on the Spiritwalk—a community-wide event that promoted Indian Heritage—and the activity-based

prevention model. Adding to the NPO/grantee stress was a growing concern among the NPO and the NAC about the viability of the partnership between the Seattle Indian Health Board and the United Indians of All Tribes Foundation. Upon further discussion, consultation, and review, the NPO decided that they would prefer a single-source provider in the greater King County area. The Seattle Indian Health Board was chosen to be the sole administrative agency during the Phase II implementation. The dissolution of the partnership left some staff and associates sour and angry; others were liberated and accepting. Shadows of this transition play in the background of Healthy Nations activities throughout the implementation period.

Phase II:

Phase I had concentrated on building liaisons with different community agencies, prompting transformation of the program assistant position into a volunteer coordinator. Healthy Nations also struggled to fulfill the complex paperwork requirements of the grant. Reporting the activities was less than straightforward and a low priority in the face of overwhelming requests and personnel issue. The hiring of an adult activity coordinator complemented that of the director, youth activity coordinator, and volunteer coordinator. In principle, this alleviated some strain, but personnel struggles due to sickness, schooling, and time demands still managed to plague the early years. Inroads into strong community agencies like the Indian Heritage School, Microsoft, Computer Technology Center, and others took constant nurturing and negotiation. The

Spiritwalk continued to demand attention, resources, and oversight, a fact that remained a point of contention between the SIHB and the NPO.

Human resources were stretched thin; even losses of associates caused delays in program growth. The death of the principal of the Heritage School was particularly difficult, a loss which was felt during the remaining Healthy Nation years. Early Phase II was challenging and rocky.

As the HNI program gained entrance and support from the established Native community groups—its effectiveness and successes more widely known—the relationship between the NPO and Seattle Healthy Nations exhibited more flexibility and coordination. The pressure from the early days lessened, and community expectations to be the “end all of health” were diminished by public awareness efforts to disseminate the Healthy Nations mission. The relationship with the NPO improved by demonstrated successes and thus liberated the program director to respond more freely to community suggestions and needs. The director matured into his role leading a very dedicated staff through personal example, hard work, and advocacy.

Seattle Healthy Nations supported and sponsored numerous and diverse drug-abuse-prevention and health-related activities. Some were successful; some were not. Some were supported with time and energy; others with money and goods. The idea was to have a presence in the communities and encourage individuals and groups to join any effort to stop the damage of substance abuse. The attitude was to respond to viable ideas and offer support to both individuals and agencies in their efforts. Healthy Nations worked hand-in-hand with the

American Indian Heritage School and the Seattle Indian Health Consortium. They worked alongside different public and private agencies such as the police department, other treatment providers, and cultural groups to provide educational and recreational activities for young American Indians/Alaskan Natives. A philosophy of invitation and non-exclusion with direct and clearly stated rules about drug use during any Healthy Nations activity underscored the public appeal and success.

Phase II implementation experienced its portion of struggle. The director was an extremely dedicated person who, along with the activity coordinators, would work 70 to 75 hours a week (almost to the point of exhaustion) out of a deep sense of duty to Healthy Nations' values, individuals, and programs. They cooked for the meetings, transported kids to different activities, organized recreational events, and taught classes at the Computer Technology Center. The staff, in concert with Microsoft support, organized a computer mentorship with Native American employees of Microsoft for at-risk American Indian youth. They coordinated the public service announcements, advertised for the Spiritwalk, and supervised the volunteers who were running cultural activities. The mentoring programs expanded during the third year to include the Boeing Native Flight program, offering the opportunity to connect Native kids with Native professionals from Boeing. Such programs provided an avenue to reach the goal of creating career and professional opportunities within the American Indian community. The Microsoft mentoring program, Microsoft's Powwow, Boeing's Native Flight program, and individual placements of kids with mentors realized

and confirmed the philosophy of active prevention. Scores of youth found alternatives to using drugs and self-destructive behaviors. Traditional respect and relationships were fostered.

The complex nature of focusing on individuals and small groups throughout the diversely cultural Seattle communities proved challenging and instructive. As the community voice was heard and supported, the concept of a central community advisory committee gave way to more natural and specific sources of direction. Each community group became a coordinating council for their individual programs. Mobilization of the Healthy Nations resources reflected the larger community through listening to and sustaining existent infrastructures. It was from these adjustments that Seattle Healthy Nations realized its initial hope of coordinating existing community resources. To allow each of the individual participants and groups to be the defining source of “culture” was insightful and productive. The inclusive attitude and flexible resource management allowed responses to requests that seemed viable and preventive in nature. In fact, the director was told by one of his staff: “the thing that makes Healthy Nations successful is that before Healthy Nations, no one would have thought that all of these weird people would be in the same room.” This statement was in reference to the number of community participants there—from the University of Washington academics, researchers, police officers, health providers, gang leaders, youth participants, families, and elders—talking about how best to help kids and families get away from substance abuse. The initial objective of Seattle Healthy Nations of supporting culture in its diversity and

diffusion in King County became its hallmark and legacy—cooperation through respectful listening, hard work, and individual focus.

Highlights:

A gathering of American Indian and Native Alaskans from the Greater Seattle area—the Spiritwalk—experienced unprecedented expansion. Tribal members walked through the city in celebration of their culture and heritage and out of respect for those who had gone before. The Spiritwalk's success demanded more volunteers, more support, and more oversight by Healthy Nations staff. The NPO believed that too much emphasis was being put on the Spiritwalk at the expense of the other Healthy Nations components. The director strongly argued that the Spiritwalk was their gateway to wide public awareness and that it provided a common ground with the cultural diversity of Seattle. He posited that it represented the greatest collective opportunity to fulfill the mission of Healthy Nations by providing the best means for getting their positive sobriety and cultural pride messages on the street and into the communities. This point of negotiation remained active throughout the grant cycle. The Spiritwalk continued as a central component and legacy of the Seattle Healthy Nations program.

An attitude of inclusion and response to the wants and interests of youth instead of imposing prescribed activities on them helped to create an outgrowth program, "Red Eagle Soaring." Red Eagle Soaring is a theatre group that utilizes Native storytelling and acting to share stories about positive American Indian role models, Native lifestyles, cultural heritage inclusion, and anti-drug and -alcohol

messages. This little troop of thespians performed in schools, at community events, and at Native gatherings, including other Healthy Nations grantee sites. Healthy Nations sponsored performances; provided transportation, advertisement, props, and rehearsal lunches; and occasionally supplied pizza after evening events. The effectiveness of Red Eagle Soaring is demonstrated in a vignette of a young Native woman teetering on the edge of self-destruction due to substance abuse. Her natural talent and love of acting drew her to participate in Red Eagle Soaring, and she soon dedicated herself to the pursuit of her talent and love. The messages of hope, pride, and sobriety found their place in her. A year after the end of Healthy Nations, she met the ex-director at a municipal function and reported being the executive producer of a play getting rave reviews throughout the Greater Seattle area.

Although there was competition and some duplication with other community agencies, Seattle Healthy Nations became a resource support for multiple in-school curriculum and cultural activities. Maturation of the Seattle Healthy Nations program confirmed the philosophy of active prevention. The activities themselves were not the end goal. Numbering the events or counting the participants gave way to focusing on individual kids. Not all attempts to accommodate requests from the community or target staff identified needs or met with success. One such program—Open Gym Night, an idea for late-night activities—floundered and eventually closed. This attempt to provide healthy alternatives to youth prone to wandering the streets or participating in gang activities proved dangerous and ill conceived. Lacking sufficient supervision and

security, the late-night-activity idea exacerbated the worries of the director. Inadequate community resources together with insufficient collaboration hastened the demise of this activity. The staff learned and refocused energies into different and more successful after-school programming.

The Microsoft mentoring program placed youth in contact with successful Native mentors working at Microsoft. A successful project, it fulfilled part of the vision of Healthy Nations. As an activity that taught marketable skills as well as bridged generational lines, the Microsoft mentoring program was without peer. Scores of American Indian youth and their families were given the opportunity to associate with the most successful corporation in the Northwest. This program not only served to broaden Native community interaction but also helped to counter alienation of youth from adults and to provide alternatives to negative lifestyles. It was so successful and respected that Microsoft allowed a Pow Wow to be held on their campus; one year, over 500 people attended. Healthy Nations provided food, gifts, entertainment, and transportation for participants. Such success encouraged the establishment of other mentoring programs such as the Boeing Native Flight Club. Engendering cultural pride and identity through association with modern professionals and business people served to give healthy options, hope, and meaningful skills to those youth and adults involved. Pride in their heritage and the invitation to give back to their communities proved to be an outgrowth of these mentoring experiences.

Another successful program was “Summers Options.” This alternative activities program targeted the boredom youth experienced during long summer

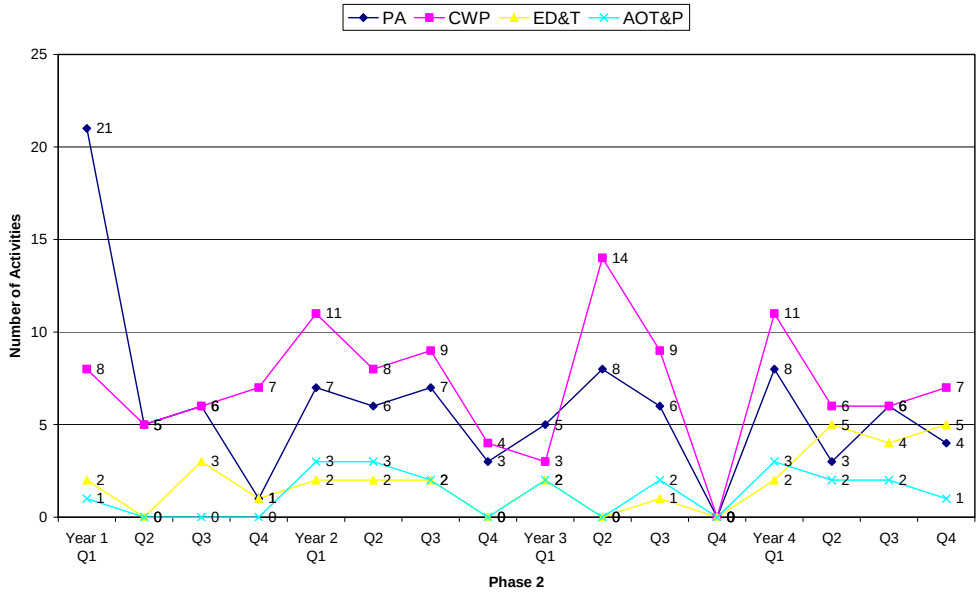
days. The Options program succeeded in creating an atmosphere of pride and hope for many young people through exposure to culturally relevant experiences. The Options program was co-located with the SIHB treatment programs, thus offering a controlled and supervised environment. This program placed referred youth in contact with recovery, culture, and caring adults. It proved inviting and effective. One story illustrates the individual focus and human success of the Options program. A very large, 15-year-old gang-want-to-be started coming to the Summer Options program. He exhibited the “angry-at-the-world” attitude and bravado generally associated with gang membership. As a mixed American Indian and African American, he had significant racial identity confusion. He posed a daunting challenge for early intervention and prevention objectives. The Healthy Nations staff kept inviting him, including him, and reaching out to him. He learned how to bead and participated consistently, although not always fully. Through a positive relationship with Healthy Nations staff members and a growing sense of personal accomplishment, this young man’s attitude and demeanor changed—an angry boy designed and beaded a sense of belonging. After a few months, he proudly announced to the staff that he had finally learned how to do something, and he remained in the program for about 2 ½ years. Today, this young man is productive in the community, has given up his gang affiliation, is gainfully employed, and has established a connection to his cultural roots. Here the measure of success is an individual life and future. His story reflects the vision of the Seattle Healthy Nations program and staff.

A poignant and conclusive story about the efforts of Seattle Healthy Nations and the impact of community partnering concerns a homeless couple. It was reported that a homeless couple raised $100 by gathering cans and other sellable items and donated it to the Spiritwalk. They felt compelled to help continue this great representation of American Indian spirit and the good work of Healthy Nations. Its message is unwavering about wellness and sober pride.

Red Eagle Soaring has community sponsors. The cultural aftercare component, the Options Program, is now a permanent part of the treatment curriculum. Prevention awareness and strength through coordination has continued in the philosophies of other agencies. Community collaboration was solidified notwithstanding the early tensions. Many individuals were helped and continue to give back to their communities and their people. Some youth were guided to career paths; other participants have gone on to university studies when otherwise they might have lost their way.

Staff matured, grew, and expanded their skills and connections to the community sources of power and change. Even where a community was undefined, there is a core—a voice that needed to be heard and supported. Healthy Nations learned to hear these voices. These Healthy Nation staff now represent, in different agencies and different communities, the same ideals, respect, and ethic provided by association with this unique grant.

Seattle Indian Health Board Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Twin Cities

Minneapolis/St. Paul, Minnesota

Healthy Nations Program

December 1993 – November 2000

“Framing a Structure of Cooperation: Youth Mentorship and Leadership Capturing the Vision and Building the Future”

Twin Cities Minneapolis/St. Paul Narrative

Historical Context:

The Twin Cities Healthy Nations Program is situated in the Minneapolis/St. Paul metropolitan area. This area in southeastern Minnesota is home to over two million residents of which 25,000 are American Indians living in seven counties. The Native American populations are primarily a mixture of Ojibwa, Lakota, and Dakota peoples, but members of numerous other tribes and bands also live in the greater Twin Cities area. The American Indian community is unusual due to the urban setting and the architecture of city communities.

The Twin Cities Healthy Nations Program served a high-density Indian community within the south side of the city, a suburban population at Pryor Lake and recent increased immigrant reservation population at Prairie Island. Indian communities within this urban setting faced a greater proportion of social ills than surrounding non-Native populations. Drug abuse, alcoholism, gang involvement, and poverty are among the negative consequence of urban living over-represented in Native communities. The Twin City Indian population is generally younger and suffers a negative disparity of wealth and opportunities in the workforce. In the early 1990s, the American Indian unemployment rate was 19.3 percent, many times that of non-Native individuals. In one county, the 1990 data revealed that 61 percent of Native children lived below the poverty level with 75 percent of the families headed by single parents. American Indian youth in high

school are dropping out at an average rate of 27 percent, four times that of their non-Native counterparts.

A 1989 report (McMahon) indicates that, on the average, the urban Indian population drank less than their reservation counterparts. The same report concluded that 80 percent of the males and 74 percent of females that did drink were considered “problem drinkers.” Young adults between 18 and 34 years of age constituted the grouping most likely to engage in such problem drinking. Further, the report indicated that approximately 12 percent of Native adults in the Minneapolis/St-Paul area reported drug use. Although only two percent higher than the non-Native adults, these disturbing data highlighted the severity of the substance-abuse problem in this urban Indian population. Related issues such as criminal offenses, juvenile detention, and victimization are disproportionately represented in this target group. Data from the same time period indicated that almost 94 percent of criminal justice problems were connected to substance use.

Poverty, crime, and drug use stripped the communities of important human and cultural assets, robbing the American Indian communities of optimism, hope, and pride. Suicide, accidental injury, and teen pregnancy that accompanied the substance-abuse epidemic of this region were nearly double the rate of other groups and the general U.S. population. Compounding the insidious destruction of the culture by alcohol and other drugs was the diffusion of traditional structures lost in the difficult context of big city living.

Because of the metropolitan nature in the Twin Cities, there were no direct tribal authorities that represented all the different American Indian groups.

Complex governmental structures within the Minneapolis/St. Paul metropolitan area addressed and regulated Indian concerns. These entities included the BIA, IHS, and other federal and state agencies and bodies. Over 150 organizations had a stake in the provision of services to the American Indian populations. The Indian Health Board and the American Indian Center are recognized as just two of the central providers of health and substance-related services in the greater Twin Cities area. These two organizations have a long history in the communities and are connected to numerous other agencies.

Forty-three service providers and American Indian agency heads acted as a steering committee in the preparation of the original Twin Cities Healthy Nations Phase I proposal. This committee guided the early planning efforts but soon existed mostly on paper. A central group of eight on this committee remained active throughout the Healthy Nations project, serving as the advisory board. The steering committee debated the most appropriate agency for locating the grant management. Since the proposal represented the larger American Indian community and the many agencies serving it, this decision was critical. Options were narrowed down to the Minneapolis Indian Health Board and the Minneapolis American Indian Center (MAIC). The administrative ties of the Indian Health Board with the University of Minnesota and the medical model appeared to sway the decision to locate the Healthy Nations Initiative in the American Indian Center. Healthy Nations ideals and four major components of the Robert Wood Johnson grant favored the administrative model and program constitution

of the Minneapolis American Indian Center; thus, the committee identified the MAIC as the managing recipient of the Phase I planning and development grant.

The future and first HNI director attended the pre-grantee conference and sought to respond to Robert Wood Johnson RFP. She informed the committee of the limitations of the grant award, prompting a change in vision and structure. Initially envisioned as expanding a free-standing substance-abuse facility managed by the Minneapolis American Indian Center, the Twin Cities Healthy Nations proposal underwent a revision even prior to the Phase I grant award. The direct service enhancement idea gave way to a more consonant grant philosophy of the community's joining in a coalition and sharing resources. The proposal was successful, and the Twin Cities Healthy Nations program commenced.

The Twin Cities Healthy Nations program embarked upon an ambitious and far-reaching program of trying to increase cooperation and coordination among agencies that provided drug and alcohol prevention, education, referral, and treatment. The Twin Cities Healthy Nations program employed a large research-based community survey project to help define the community's needs and change readiness. Initially, the survey was designed as a direct household mailing; however, this proved not to be feasible and too time consuming. A series of key stakeholder meetings, including the participation of identified Elders, replaced the more ambitious direct-mail design. The steering committee and MAIC administration concluded that this needs assessment tact would be the most informative and applicable to the Phase I development and planning stage.

Phase I:

The community needs assessment process consumed a significant portion of Phase I time and resources. The feeling was that such a survey would be a unique opportunity to identify needs and strengths of this underserved and understudied urban Indian population. Energies were focused on developing a well-constructed survey tool, arranging community forums, conducting key stakeholder interviews, and preliminary data analysis. The director and a project coordinator, both of whom were academically oriented, dedicated themselves to this endeavor. This dedication and interest in the survey not only bridged the community involvement component but also addressed the proposal concept of agency cooperation and coordination.

The personality and leadership style of the director transcended, in a stepwise process, many historically situated barriers. Politics and allegiance within the different agencies and communities posed roadblocks to the realization of the vision of collaboration. Overcoming these barriers necessitated a laborious and thoughtful outreach effort on the part of the director in bringing together many of the 150 agencies. Having joined the Twin Cities Indian complex relatively recently, the director succeeded in connecting previously disaffectionate partners due to her lack of historical connection or allegiance. Over the next eighteen months, having focused on survey instrument development, methodical negotiation with agency heads, and some analyses of

the data, Healthy Nations emerged as a central resource for the region. The survey process and resulting data were rich sources of information and learning.

Relationships were built, community voices were heard, and plans were drawn to address the grant components. Not all was smooth and positive, however. Along with the increasing data came subtle and erosive community concerns. These concerns focused on a perceived imbalance between action in the community and the gathering of information. Such a reaction reflected the historical outcome of many initiatives started in these communities. Some community members concluded that much would be known but little would be done.

“The Healthy Nations Needs Resources and Networking Assessment,” the assessment project, underscored the belief that culture and tradition held healing and protective power. A clash between a well-intended scientific inquiry and the sacred ceremonial life ensued. The program director and staff designed a pilot program to demonstrate the strength and curative factors of certain aspects of culture and tradition. The effort was to set up an experiment to test the effectiveness of sweat lodges. The data and experience of this experiment was thought to be able to inform the addition and application of similar cultural activities to existing treatment programs. Community stakeholders voiced their feelings that the experiment was inappropriate due to the sacred nature of the sweat lodge. As a result, the research pilot program was discontinued. Alternative methods to infuse culture were explored throughout the course of Healthy Nations. This sensitive response to the community concerns

strengthened the image of Healthy Nations. Other activities addressing the grant components were undertaken. Consistent and potent public awareness campaigns were initiated. Cooperative ventures in promoting substance-free gatherings and joint sponsorship of community activities complemented the community survey. The name of Healthy Nations and the availability of community resources became widely recognized.

One such positive joint venture was a large conference, “The Gathering of Healthy Nations Conference” in association with the American Indian Mental Health Association. This association caused some confusion to the identity of the Healthy Nations Program. Notwithstanding public misidentification of the conference with the program, association with a successful conference enhanced the status of Healthy Nations. The conference defined the Healthy Nations program as a resource organization.

An outgrowth of this initial conference was a successful youth Pow Wow, an event which gathered together 800 people in the spirit of community while enjoying healthy activities. Using the powwow environment, Healthy Nations presented culture and tradition as media to promote pro-social messages and community cohesion. These two community activities served as public awareness venues for Healthy Nations and also acted as an avenue for eliciting feedback from the community. The program was emerging as a responsive force in prevention and public education.

Phase I demonstrated a logical planning dimension—a concerted apolitical influence demonstrated through coordination and collaboration without

ownership. A deep spiritual dimension unfolded and was encouraged by listening and joining with the communities, especially the elder and natural leaders. These program qualities along with the growing community demand for action helped set the stage for Phase II. Spirituality as prevention was the principle effort Healthy Nations had targeted in their preparation for Phase II. Twin Cities had a sophisticated compilation of data, opinions, and ideas. Much of the survey information appeared to have limited immediate value due to the complex nature, the sheer amount, and the less-than-optimal community representation (greater proportion of providers than community members). Nevertheless, Healthy Nations seemed poised for a launch into Phase II.

Transition:

The transition from Phase I to Phase II became complicated. The director opted to return to graduate school, creating a leadership change right at a time of the approval and initiation of the Phase II proposal. Shortly thereafter, the coordinator also returned to finish her degree. The leadership loss was substantial and ill-timed. Corresponding to the shift in leadership, the NPO increased the dialogue regarding the academic nature of Phase I efforts. Hoping to steer the project toward a more action-based program that would address each of the proposal components, the NPO conducted a site visit. During this meeting, the new director was introduced to both the possibilities and expectations of the grant. He also used this forum to introduce his concept of program management and vision. He was immediately charged with fulfilling the

proposal's objectives with which he had little familiarity. Thus Phase II began a different path to prevention and community empowerment.

The Phase II director was relatively new to leadership positions within the larger community, but he had an extensive background in chemical dependency treatment and prevention. The strength and personal commitment of the first director lent momentum to the vision inherited by the new director. Immediately, the director was thrown into negotiations with the NPO and called upon to explain past activities as well as to construct future efforts. Regarded as a very conflicted and difficult meeting, the director demonstrated an equally strong commitment to the philosophy of community joining and support. Without total history of the previous Phase I activities, he attempted to respond to the four proposal components. This process of transition and reworking the proposal covered many months, including a second site visit. Eventually the NPO approved the continued funding of the Twin Cities based on the revisited proposal and shifted focus. This focus was a concerted effort to demonstrate action in the communities. Hoping to avoid the disillusionment common among community members, the new director pledged strong program visibility, increased energies, and more action. The new director worked hard in trying to revisit the goals and objectives underneath the components of the grant. Phase II objectives were built upon the collaboration and traditional activities initiated in Phase I.

Data and community requests consistently pointed to the need for more youth programs. Impacting Native youth through traditional and healthy events gained prominence in the Healthy Nations list of prevention activities. The

director knew that lack of cultural identity and dearth of cross-generational relationships was threatening the future of the American Indian communities. The constant message for the community prompted a more focused youth-oriented evolution of Healthy Nations.

A central component of the Healthy Nations program was a mentoring project that connected at-risk youth with healthy Indian role models. The director worked diligently, along with Healthy Nations staff, to establish a mentoring program that was culturally and traditionally specific to the mentee. This proved to be a challenging endeavor. At-risk youth in need of or desiring mentoring always exceeded the healthy, culturally-matched mentors, which forced a transition into using any available ethnic mentor generally matched with the youth. Notwithstanding this adjustment, youth demand always out-stripped the available adults. A time and resource intense program, the investment in skills training for the mentors and arranging opportunities for youth/adult contacts bore lasting results and overlapped constructively into larger community activities and in-school functions.

It was apparent that the Indian youth needed to have an alternative to life on the street. The director and his staff knew that activities in and of themselves were not adequate to prevent substance abuse or the attending problems. Therefore, Healthy Nations responded across many categories of programmed activities, always including planned teaching moments and healthy expectations. The director and staff utilized the association with the Indian Center and created attractive alternatives to destructive lifestyles. Mottos and programs such as

“Healthy Nations, Healthy Options” and “Shoot Hoops–Not Each Other” led Twin Cities to become known as the Healthy Nations sports leader. Successful advertising of and providing opportunities for volleyball, basketball, and rollerblading to a variety of age groups helped touch individuals through sports. Team competitions, supervised games, and safe gatherings facilitated familiarity and common concerns even among rival factions.

Positive relationships, healthy group affiliation, and the infusion of cultural messages provided participants with opportunities to experience success and self-esteem. Enhancing the lessons learned through sports, the staff targeted other opportunities to influence the youth. In-school youth activities, development of leadership curricula, arranging traditional and cultural opportunities, and participating together in traditional ways were some of the Healthy Nations tactics. In association with the network of providers, positive Native identity and culture emerged as strong medicine in addressing substance-related problems.

Healthy Nations staff availed themselves of every avenue to reach the youth. Hundreds of youth attended the powwows and conferences, took roles in Indian school leadership seminars, and participated in the sporting events. Public service announcements, media sources, and program activities were infused with healthy messages and a call to tradition and pride in American Indian heritage. Healthy Nations co-sponsored events with other providers and community organizations. It spent its resources to support parents and families. The staff taught classes, organized conferences, refereed basketball games, wrote curricula, and consulted with other provider agencies. Mentors and youth were

instructed on working together; elders and community leaders were respected and supported in their grass-root efforts. The director and staff fashioned a strong working relationship with the NPO and offered support to other Healthy Nations grantees. Overcoming dissent, negotiating complex systems, and translating requests into action through a simple formula of joining without ownership defined the end stages of the Twin Cities Healthy Nations program.

Highlights:

The mentoring program aimed to connect at-risk youth with healthy representatives of their culture. The training and skills development undertaken for the mentors served two purposes: first, direct skills in interacting with these kids and, second, reinforcement and recognition of the power of their example. This provided incentives to remain involved and strengthened the commitment to changing their communities. Mentors not only reached out to and helped individual youth but they also added to the core of natural healers and activists in the area. This program always had more kids than mentors. A mixed blessing, the youth were grouped in activities and Healthy Nations-sponsored events coupled with a mentor. Having more than one youth diminished the individual attention but acted, on some occasions, to construct reinforcing peer relationships for the youth outside formal gatherings. The shift from Native-only mentors to any ethnic group engendered cross-cultural respect and a wider community of support for these youth and their culture. The mentoring program thrived throughout Phase II and even adapted the concept into school-based

programming. Many relationships established during this period remain vital and positive. It is believed that some of the mentees, now adults, are reaching out to other youth. A latticework of caring and positive example is the legacy of the Healthy Nations mentoring program.

The initial Healthy Nations collaborative philosophy continued to play an important and central role in the success of Healthy Nations. Identification of Healthy Nations as an active sponsor and advocate for youth solidified the network of providers and earned the trust of the communities. The near constant public awareness campaign, the tireless outreach, and the successes of program-specific events stimulated coordination, community acceptance, and positive publicity.

The original needs assessment provided data that informed other agencies' programming. The 43 original steering committee members provided direct dialogue and initial support for Healthy Nations. Eight members eventually became the core advisory group. Continuation of these relationships formed in the beginning facilitated project-specific cooperation and synergistic effects. Consultation with Healthy Nations staff, the elders, and the youth lead to a greater inclusion of tradition and culture in services delivery models. A legacy of the Twin Cities Healthy Nations program is the knowledge that collaboration and sharing can and does work.

Flexibility with resource allocation, small contributions to numerous activities, well-fostered interagency relationships, and a treasure trove of data were leveraged into more funding for the different agencies and events.

Association with the Robert Wood Johnson Foundation, proven events, research capability, and strong leadership contributed to ongoing funding opportunities and the preservation and continuation of many prevention and treatment components. Healthy Nations established a framework and vision very attractive to state and federal agencies. Acknowledgement of Native-administered institutions that focused on traditional beliefs has taken the form of continuation and demonstration projects reflecting Healthy Nations principles and methods. The initial grant monies have been greatly multiplied through shared resource allocation, new grant funding, and private investment.

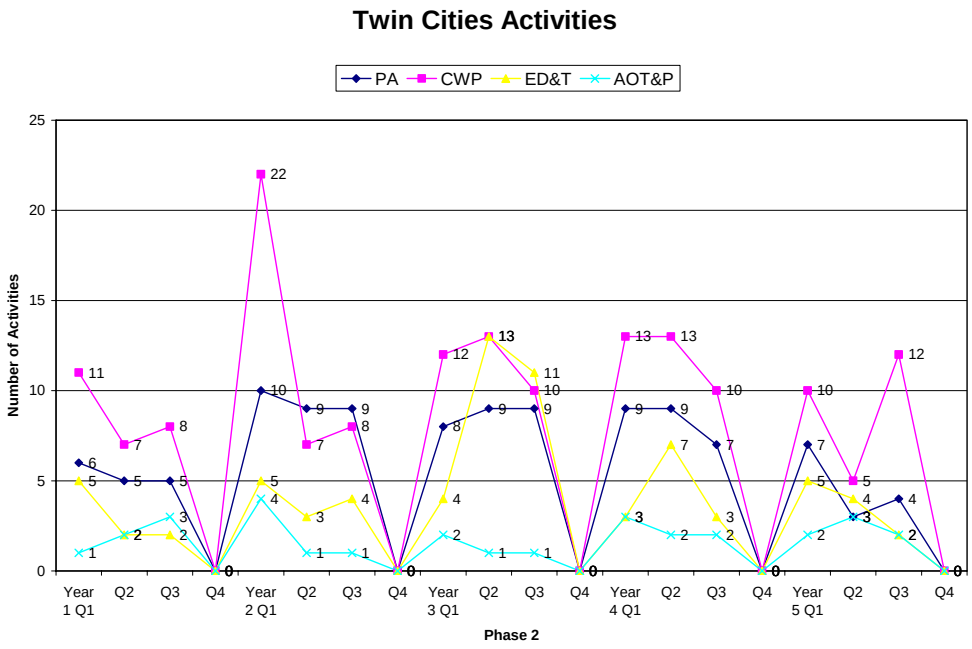
Trust and support from the NPO was earned through successful event planning and reasoned used of the flexible funding. The evolution of this critical relationship shaped the leadership resolve and commitment to the Twin Cities ideals. The opportunity for youth to have voice and leadership found ground to become the cardinal prevention and early intervention strategy. This realization helped spawn continuing adjustments to working with groups of youth identified as potential leaders. It re-apportioned effort to allow youth to obtain training and connect with their culture. This attitude and effort effectively addressed the problems of urban Indian communities and Native students. Leadership development and cultural revitalization and identification continues on under the name of Healthy Nations. The director remains within the community, working alongside the new Healthy Nations program in a private project targeting American Indian youth leadership skills training. He also continues to support the new Healthy Nations program funded through alternative grants and

institutions within the consortium. Youth leadership development, raising the next generation with skills to perform the sacred and the secular without confusion and failing hearts, is the crowning achievement of the Twin Cities Healthy Nations program.

Individuals associated with Healthy Nations were a highly prized commodity. At times this did prove somewhat disabling to the attainment of goals and delaying some projects. Leadership skills demonstrated by Healthy Nations staff were noticed and more career path and higher paying jobs would attract them to leave. Because of the stability of the Phase II director, the Twin Cities Healthy Nations Program was able to create a foundation for the Indian communities to have a greater voice, to reintroduce Native youth to a sense of cultural identity and pride, and to support youth leadership within the school district and the communities. Healthy Nations utilized coordination and co-sponsorship with flexible funding alongside other service providers to mend old fences and present a well-planned array of prevention and traditional activities.

The Twin Cities Healthy Nations program continues to have long-lasting effects. Those who grew with the Healthy Nations project carry the vision forward. Natural leaders in the communities found recognition and support. Youth leaders and mentees are poised to assume greater roles in revitalization of culture and prevention of the destruction of years past. Past leaders and staff remain vital contributors to a healthy community. Detractors who predicted failure and the usual poor outcome have been silenced by the success and persistence of Healthy Nations and its current iterations. American Indian pride and hope

seems unassailably brighter and the future more positive. Problems still exist. Youth and young adults still abuse substances, but the foundation for the slow change has been laid convincingly through Healthy Nations.



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

United Indian Health Services

Eureka, California

Healthy Nations Program

December 1993 – March 2000

“Supporting Cultural Enhancement, History, and Human Capital in Battling Substance Abuse”

United Indian Health Services Narrative

Historical Context:

The United Indian Health Services, Inc., (UIHS) is a consortium of tribal services in Northern California established about 30 years ago. It serves the Native Americans living in and around the Humboldt and Del Norte counties in Northern California. This is a beautiful area with redwood forests, rugged coastline, salmon-rich rivers, and abundant wildlife. It has been occupied for thousands of years by four major indigenous peoples: the Yurok, Wiyat, Tolowa, and Hupas. Today this area of northern California is divided into eight tribal reservations or Rancheria: Bear River, Big Lagoon, Blue Lake, Elk Valley, Resighini, Howonquet, Trinidad, and Yurok (excluding the separate Hupa reservation). Many community outposts remain relatively isolated—off road systems and surrounded by dense forests and steep mountains. With approximately 4,500 square miles in area, the UIHS catchment is home to 10,000 residents with roughly 4,500 being Native Americans.

Rich in lumber, gold, and wildlife, the area was a natural target for homesteading. History demonstrated that European incursion had significant impact on the local cultures. The prospect of wealth spawned a severe land grab, timber and resource exploitation, and a history of unsavory and sad encounters with the predominantly white settlers who came into the valley. The greatest contact took place in the early 1850s; by the turn of the century the indigenous

population had been decimated either by disease or by atrocities between the clashes of the races and cultures. Finally, the U.S. government established a reservation for those remaining American Indians. The reservation remained intact until the time of the Federal termination process in the early 1930s and ‘40s. During this period the U.S. government stopped participating with many of the smaller tribes, leading to further encroachments on Indian land and, in turn, triggering more discrimination and a further decline in the culture and health status of the remaining tribal members. Today, the reservation area is considerably smaller than what was originally established at the turn of the century. The numbers of tribes now are integrated within the four existing groups.

The area is currently struggling with declining timber and fishing industries, which has impacted tribal unemployment rates. A county employment survey in 1991 indicated 75 percent unemployment for the Yurok tribe. Social and economic disparity between the tribal communities and the non-Native communities continues to be pronounced and results in greater poverty, social ills, and substance abuse.

Substance abuse problems are reflected in the UIHS service records. Eighty-eight percent of the annual 750 clients seen in Child and Family Services had experienced violence; 60 percent of the adult clients seen had primary substance abuse diagnoses; while 70 percent of 11-to-19-year olds carried these same diagnoses. A majority of those seeking any medical service experienced both substance and mental health issues.

A 1980 American Cancer Society survey indicated that Native American students in grades 7 through 12 had an overall 30 percent greater rate of any lifetime tobacco use and 100 percent greater rate of current use than that of Caucasian matches. Another survey, Report on Student Drug Use in Humboldt County, revealed that this county is higher in eight of fifteen categories of substance abuse than California averages. Comparing Hoopa Valley High School with greater Humboldt County showed the Native Hupa population ranked higher in eleven of the categories. In 1992, the Center for Indian Community Development conducted a comprehensive educational needs assessment which addressed community health care needs. Three of five of the top priorities were related to substance abuse, with alcoholism ranking number one.

The 30-year history of UIHS demonstrates the determination and willingness of the local tribal leaders to address the health, medical, and social service disparities between them and the surrounding county. Partnering with government agencies throughout the state, the UIHS has worked concertedly for greater well-being and health for its members. In 1989, using California tobacco taxes, UIHS and the Hupa Health Association instituted a broad-based health education program. Targeting tribal youth, this partnership formed the Teen Advisory Group (TAG), which uses theater, newsletters and workshops to promote healthy choices. Programs specific to alcohol and drug prevention are sponsored by this partnership. Three in-school prevention projects were offered through different grant awards in 1992. UIHS, being representative of the tribes,

had chosen to address substance abuse and drug use in their communities many years prior to the Healthy Nations Initiative.

UIHS has developed some treatment services intervening with substance abuse, but a major service deficiency is the lack of residential treatment for youth. Providing outpatient, referral, and linkage to community support group services, the UIHS recognized its insufficient resources targeting treatment of substance abuse. In 1992, the UIHS conducted an extensive strategic planning process. The Planning Task Force consulted with all communities and key stakeholders. The resulting five-year UIHS plan concluded that the second priority was to “improve patient accessibility and program effectiveness for substance abuse services.” The actions of the next five years underscored their commitment to realizing these goals.

UIHS had two departments providing prevention and intervention services to substance abusers and at-risk youth. The Health and Wellness Department had seven staff members that provided health education services. This department housed the Teen Advisory Group. UIHS had separated their mental health and substance abuse from their medical department early in the 1990s. Needing to transcend the “medical model” previously guiding these services, UIHS formed the Child and Family Services Department. This department provided individual and family outpatient counseling and substance abuse counseling. The staff works closely with affiliated agencies, contract treatment providers, and school districts.

Phase I:

When Robert Wood Johnson offered the Healthy Nations Initiative, UIHS decided to pursue this grant opportunity to augment existing services. The director of the Child and Family Service Department acted as the key person. In collaboration with Humboldt State University, she initiated a substance-abuse specific-needs assessment, and extensive exploration with stakeholders, community programs, and UIHS personnel was completed. However, this person who was important to the proposal left the area prior to seeing the grant proposal funded. Preparation for the Phase I proposal included visits and consultation with the High Plains Youth Center. This visit increased understanding about youth treatment and aftercare—central components of the grant. In 1993, following enthusiastic support from the board of UIHS, a successful proposal was submitted. Chosen as one of the 15 original grantee sites, this represented a collective success.

Phase I objectives targeted information dissemination and coordination of all related substance abuse and prevention services. Initial success included collaboration from all nine Rancheria, tribal organizations, specialists from Humboldt College, and State of California partners. Healthy Nations joined a vital and growing traditional/western mix of activities and services promoting increased health status on the reservations. This was an ideal fit for Healthy Nations philosophy and objectives. Healthy Nations was an important addition to the structure of UIHS.

Healthy Nations began a broad public awareness campaign and a community-wide prevention pilot in six communities. This campaign included the development of four culturally relevant anti-alcohol books for distribution in local schools. Similarly, culturally targeted public service announcements were created. Concurrently, Healthy Nations forged improving communications between regional treatment programs and aftercare providers. Joint meetings with Healthy Nations staff and clinical providers yielded stronger ties. Efforts to develop a more substance-abuse prevention-oriented presence in the schools, addiction awareness in primary care, and a greater acknowledgement of traditional “ways of being” were defined the Phase I.

Healthy Nations recognized traditional gatherings and ceremonies as ways to carry the messages of culture and sobriety. This was the main ingredient and theory for the UIHS Healthy Nations project. Healthy Nations made great efforts to reach out to the youth through such channels. Healthy Nations Program partnered with the Teen Advisory Group and the UIHS Health and Wellness Department to guide youth education and prevention efforts. Likewise, planning was underway to expand the primary mental health and substance-abuse care capacity. The strategy was to collaborate with the State of California service agencies and also to seek additional funds for treatment and prevention projects.

Such broad objectives and flexibility led to some tension. The management, direction, and control of Healthy Nations generated significant discussion and posturing among the different stakeholders. This situation colored the early development of the Healthy Nations identity formation. Diverting

energies for objective fulfillment to political and administrative issues postponed success of some objectives.

The Child and Family Services Division—better known as May-Gay-Tahl-Kwe (the healing place)—was Healthy Nations' organizational home. This proved to be quite advantageous in that this placement allowed the mentoring of prevention and cultural outreach to infiltrate existing agencies. Healthy Nations acted as a liaison between prevention and mental health and addiction services. However, leadership reassignments suddenly left the program without management, and the burgeoning programs needed consistent and focused oversight. After an extensive candidate search, the administration hired an area resident and known manager as their director. Local leaders and the Healthy Nations advisory group were extremely excited that a local person of Yurok and Tolowa heritage had applied for and secured the position. He acted as the coordinator and director of Healthy Nations throughout the duration of the program. This stability and understanding of the local culture provided for a very successful development and evolution of Healthy Nations at UIHS.

Transition:

Phase I successes in the public awareness campaign, community-wide prevention activities, and networking of treatment provider agencies necessitated the hiring of four outreach workers. These outreach workers were to help facilitate fulfilling the goals and objectives outlined in the Healthy Nations proposal. It was anticipated that such personnel could reach into the

communities and schools to convey the messages of Healthy Nations. This formed the foundation for reaching grant objectives outlined in the UIHS Phase II implementation proposal. Phase II objectives simply expanded on the original vision and planning. Documentation posed a small problem, and the NPO offered technical support to help the staff more accurately report activities addressing each grant component. This completed, UIHS was invited to participate in a NPO video dealing with documentation. This video served as a training tool for other grantee sites. Otherwise, the transition into Phase II was uneventful.

Phase II:

The beginning of Phase II demonstrated the increased community awareness of Healthy Nations. The staff was flooded with ideas. Expectations grew that outreach personnel would conduct activities in the communities. Realizing this and encouraging community volunteer involvement, the director re-titled the position to “community coordinator.” The title change subtly shifted the onus back to the community. The process of hiring the coordinators, however, experienced glitches. The problems in finding the right people for the positions impacted the ability to pursue some early project goals. Perseverance, good leadership, persistent communication, and collaboration with the National Program Office allowed the hiring of local, tradition-based natural leaders.

Personnel selection became the critical component in program expansion. Having hired trusted community leaders and tradition-oriented individuals, the program garnered greater acceptance and grew at an accelerated rate. This

staffing pattern consistently reached into the more remote communities and outposts. The messages of Healthy Nations enjoyed universal access and growing respect.

As Healthy Nations evolved, so did its influence and ability to institutionalize its principles and philosophies. Phase II saw its director named as the supervisor of the UIHS fourteen-bed adult substance-abuse inpatient program. This commingling of prevention and primary intervention allowed for greater coordination and easier completion of certain grant objectives and goals. The goal of expanding treatment options rose to prominence within the priorities of Healthy Nations. Partnering, collaboration, and coordination of services became the focus. Considerable effort was expended in gathering partners and leveraging the Healthy Nations money. Through solicitations and awards of other grants from federal, state, and local agencies, the Healthy Nations program gained greater status in the UIHS cadre of services. The program continued to join with different communities, to support volunteers, to facilitate intra-agency cooperation, and to organize drug-free traditional gatherings. The leadership and staff gained skills and reputation, and Healthy Nations resources were leveraged to expand programming and activities. The philosophy and principles developed became templates for new and old programs. Healthy Nations finished the grant cycle greatly respected and a blueprint for future ventures.

Highlights:

Aware that youth bridged two worlds, Healthy Nations set out to address this dilemma. Healthy Nations sponsored a meeting called “Success in Both Worlds Youth Conference.” This youth gathering emphasized drug-free living as well as the history and practice of their Native heritage. The intent was to infuse young people with a sense of cultural pride. Skill classes targeted decision-making processes, especially at the intersections between the Native world and the modern world. The youth learned that they could be healthy and productive living in both worlds. The first conference was attended by 70 or 80 young people, some of whom had been participants at a Healthy Nations grantee meeting; they performed impressively. This program has now become an annual event, drawing hundreds of participants. Currently, multiple sponsors including the Del Norte School District, Humboldt School Districts, UIHS, local businesses, and other agencies support the conference. The idea of supporting youth in cultural identity formation as well as in developing marketable skills remains a core objective of youth activities.

Local gatherings are important cultural events. Phase II goals proposed holding ten community gatherings for individuals and families throughout the year. Tribal gatherings in the past had deteriorated into drinking parties where the power of ceremony and healing was lost to disruptive behaviors. This had begun to change over a 25-year period through a revival of the local traditional ceremonies. Healthy Nations sought to add to this positive revival of tribal gatherings. It began sponsoring and expanding the scope and intent of some of

the ongoing gatherings, in particular, the Spring Campout, the Stick Game Camps, and an Elders Camp. Over the course of the Healthy Nations Program, these gatherings also became drug-, alcohol-, and tobacco-free promotion events. Transformed into celebrations of wellness, these camps became safe places for families and cultural teaching occasions for the youth. These gatherings demonstrated the protective and healing nature of ceremony, a central tenet of Healthy Nations. They also functioned as methods for the revitalization of tradition and dissemination of the no-use/abuse messages. Early in the Healthy Nations Initiative, participation at these gatherings was poor, but the director recalls that toward the end of Healthy Nations, it was very difficult to find a camping spot for the large number of people who were now attending.

Roadway signs relaying health and cultural messages represent one of the many positive remnants of the public awareness campaign. Many of these signs were placed throughout the reservation in conspicuous places, and today, prominently displayed on Highway 101, two of these signs proclaim their positive cultural and “no use” messages. Hundreds of people from within the community as well as seasonal travelers are greeted with positive images and reminders about tribal dedication to health and healing. The tribes today maintain this well-received prevention tool**.**

The modeling of positive Native lifestyles was the second strategy used for prevention and recovery. Throughout early Phase II, the staff, along with key stakeholders, had determined to launch a program called “Local Heroes.” The Local Heroes project intended, in poster form, to portray positive lifestyles and

messages from known culture representatives. Such a concept generated extensive discussion. Tension and disagreement over who represented the desired qualities accompanied program development; it took over a year to resolve this dilemma. Ultimately, twelve posters were produced and distributed throughout the region. These posters remain prominent in high-traffic areas such as the health clinics, schools, and local businesses. The messages highlight pride in “who you are,” cultural beliefs, and Native heritage combined with the message that drugs and alcohol are dangerous and not part of “being” Native. This has had great impact in connecting the elders and the youth. These posters also serve to remind the viewer of the unique connection to each other and the strength in traditional affiliation. Culture has been moved from the background to occupy the explicit role of importance, healing, and future.

Relationship development with communities, agencies, and tribal members was central to the success of Healthy Nations. The staff strengthened numerous networks through persistence, hard work, clear focus, and dedication to program principles. Collaboration, resource sharing, and respect for culture facilitated the creation of strong working relationships within the corporation and with outside partners. This was also true for the relationship with the NPO. Early on, the NPO questioned expenditures for food, gifts, and acknowledgement awards; however, as the relationship matured, a mutual trust ensued, bringing with it support and encouragement. Learning from this internal developmental process informed later-stage negotiations with new funding sources and service providers.

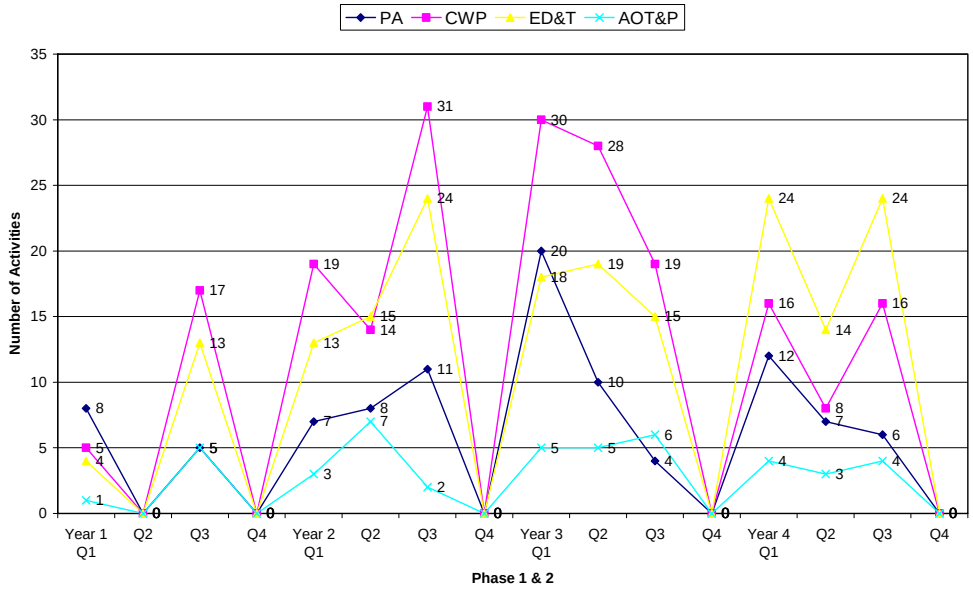
Today the Health and Wellness Department of UIHS continues the important prevention work with its Teen Advisory Group. The Health and Wellness Department along with other community sponsors continue to support the various sober community gatherings, family fun days, softball and basketball tournaments, a teen newsletter, undercover underage tobacco buys, youth presentations, a summer youth camp, and many other educational programs and services. These all have a strong cultural integration that uses local traditional beliefs and practices. One major belief is that "one must live right in life, drug and alcohol free and involved in one's culture." The Healthy Nations Initiative had a great impact on validating and expanding this local work throughout the UIHS region in Northern California.

Another challenge affecting the evolution of Healthy Nations was staff turnover. The community coordinators were severely underpaid; this was not due to Robert Wood Johnson, but it was a result of UIHS policy. Many community coordinators, exhibiting desirable skills developed through Healthy Nations, took alternative employment with greater pay. Such loss of knowledgeable leadership caused disruptions and consumed limited energies. Some objectives were abandoned or underserved during these periods. Nevertheless, association with Healthy Nations led to further individual successes and to the prevention effort in ways never anticipated initially in the Healthy Nations proposal.

Human capital proved one of the most significant and lasting assets of the Healthy Nations program. Many former Healthy Nations personnel continued to do prevention work, to occupy positions of influence, and to remain active in their

communities. These UIHS staff members carried forward the philosophy, experiences, and skills developed by working with and toward the Healthy Nations objectives. For example, the last director is now principal of an elementary school that has continued the cooperative efforts model. He has recently arranged for dental and medical services on the school campus for underserved kids. He is also responsible for having built a traditional village on the school grounds to represent pride and connection with tribal heritage. Healthy Nations cultivated local leaders and educated healthy staff who are now sharing the vision of this project in many different settings. Community coordinators are continuing to contribute to their communities in positive ways. The work continues. The UIHS Healthy Nations site was a real success story.

United Indian Health Services, Inc. (UIHS) Activities



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CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

White Mountain Apache

White River, Arizona

Healthy Nations Program

December 1993 – December 2000

**“From Program Changes to Community Connections:
The Rise of Therapeutic Culturally Based Initiatives”**

White Mountain Apache Narrative

Historical Context:

The White Mountain Apache reservation is located in east central Arizona. Encompassing 1.6 million acres of diverse topography, the reservation overlaps into portions of three counties: Navajo, Apache, and Gila. High plateaus covered with Pinion and other pine forests teaming with wildlife and low elevation desert sculpted by the Salt River define the topography. The landscape includes 25 natural lakes large enough for fishing and recreational activities and 420 miles of river and streams punctuated by the 11,000 foot Mount Baldy. Natural resources including timber, mining, and wildlife are in rich abundance and include a world-famous Elk range. Five main population centers—White River, Cibecue, Carrizo, Cedar Creek and McNarry/Nondah—comprise the home of an estimated 14,500 residents. Approximately 12,500 of the total population are enrolled tribal members, an estimated 10,000 of whom are White Mountain Apache Tribal enrollees. The remaining American Indian residents are primarily Navajo. The many non-Native residents comprise the ranks of IHS, BIA, educators, and federal and state employees.

Relatively isolated, the White Mountain Apache reservation is 190 miles northeast of Phoenix and is surrounded by small, non-Native communities. The largest non-Native contiguous community is Show Low with a population of approximately 5,000. In addition to these population centers, the reservation and

surrounding area is dotted with outposts of Native family and small-group living sites. This arrangement of enrolled individuals living throughout the catchment area poses a challenge for providing even and consistent service and governmental oversight.

The region has also been significantly impacted by religious missionary activities and secular influences. Some traditional Apache customs and ceremonies have been lost or diminished through the process of dilution, conversion, and decreased community cohesion. Thirty churches, mostly Christian, have established congregations and practices on the reservation. This religious matrix, as well as the advent of modern media and secular education, has created competitive tensions and belief conflicts that further fractured the waning sense of Native tradition and community. Consequently, cultural identity and historical relationships were dislodged as the medicine for healing long-term effects of substance abuse and attendant social problems.

The seat of tribal government and services is located in Whiteriver. This reservation community was home to 11,500 of the White Mountain Apache residents. Encompassing the town of Whiteriver and the unincorporated contiguous areas, this corridor is the location of the centralized tribal government and health services. It also serves as the center for tribal corporate endeavors. Although the Fort Apache reservation was established in 1880, tribal government did not operate independently until the Tribal Constitution was adopted in 1952 under the Indian Reorganization Act of 1934. It is amended regularly. The 1994 revision of the constitution included a new tribal membership blood quantum

requirement that council members be fluent in their Native language, signaling attention to the revitalization of culture and language.

Tribal governance consists of a chairman, vice-chairman, secretary, and treasurer. The chairman and vice-chairman are elected at large. Four voting districts elect nine council seats. Three districts fill two council positions each while one district elects three members. This tribal council government structure is authorized to act on behalf of the members and enter into contracts with other governments and private entities. With the goal and vision of providing a “higher standard of living, better home life, and better homes within the reservation,” the council structured tribal government departments to facilitate reaching this goal. The Tribal Health Authority, largest of tribal departments, operated the Health Education program, the Apache Behavioral Health Center, and the Rainbow Center (an alcoholism and substance-abuse residential treatment center). Other tribal departments include the tribal court system, tribal law enforcement and safety departments, and the economic development arm of the tribal council.

Notwithstanding the rich natural and governmental resources available, the reservation residents faced problems with substance abuse and alcoholism. Consistent with national trends in substance-abuse morbidity and mortality, the White Mountain Apache people had struggled to maintain efforts to address substance-related death and injury as well as loss of culture on the reservation. Even with twelve revenue-producing enterprises controlled by the tribe—including successful timber, hunting, and casino businesses—1993 Department of Labor statistics indicated that Navajo and Apache Counties were the sixth and

seventh poorest counties in the nation. With a median per capita income less than 50 percent of that of the State of Arizona, 40 percent of the residents of these two counties were living below the poverty line. Unemployment on the reservation peaked at 61 percent during this time—ten times the state average and many times the national rate.

Compounding these circumstances, data collected during this same period showed that many Native Americans living in this area had not attained a high-school graduation diploma or certificate. Education problems included an excessively elevated school drop-out rate (200 percent of the state average) and a significantly limited post-high-school college rate (1.3 percent). As is common with communities plagued with poverty and poor educational attainment, substance-abuse problems were over-represented on the White Mountain reservation.

A 1990 estimate of the extent of the alcohol problem indicated that between 40 and 60 percent of tribal membership met the criteria of alcoholism. The tribal chairman noted in the proposal pre-amble: “no tribal members were not affected by this (problem)”. Whiteriver Hospital records (1991) showed that 43.3 percent of all admissions were alcohol related. In 1992, death records indicated alcohol as the primary cause of death for 42 percent of all adult deaths between 21 and 74 years of age. IHS data spanning a similar time period indicated that 48 percent of all injuries requiring hospitalization were alcohol related and cost upwards of $4,000 per incident. Youth-specific data paralleled those of adult medical records. A 1992 community taskforce targeting prevention of fetal

alcohol syndrome conducted a survey of 589 tribal youth between 10 and 18 years of age. The data showed that 50 percent of Apache males and 44 percent of females used alcohol regularly. Uses of other substances were noted, none reaching the epidemic proportions of alcohol. In this same survey, the students indicated that alcohol abuse was either first or a close second to sexual/physical assault as primary concerns facing the reservation and their lives. The 1992 Whiteriver Unified School District Substance Abuse Survey confirmed the above findings citing high school students endorsing a 60 percent lifetime use of alcohol with over half of these students endorsing regular weekly use. These data revealed the broad extent of the alcohol-related effects evidenced by 30 percent of the respondents indicating that a family member was regularly intoxicated. Other surveys of this time period painted the same disturbing picture about substance abuse at White Mountain Apache reservation.

Tribal leadership and many community members had long been aware of the problems and had sought to address them. Starting in the 1970s, the tribal council had made numerous resolutions and taken actions against various associated topics, including Fetal Alcohol Syndrome (1981), Non-medical Detoxification Services (1981), Tribal Liquor Ordinance (1986), Tribal Omnibus Act including a Tribal Coordinating Council (1986), “No Drink to restore Harmony Day” (1989), and The Community Crisis Response Team (1991). Tribal resources were expended to create the Rainbow Center, an inpatient substance-abuse treatment center, and an expansion of the overall Tribal Behavioral Health services. These are just examples of the efforts to address problems disrupting

the community. A sudden spike in suicides of young males on the reservation in 1992—many related to alcohol—punctuated the battle and difficulties in coordinating a united strategy to fight alcoholism and drug use. The then tribal chairman declared war on substance abuse. This increased focus included the RWJ call for proposals for the Healthy Nations Initiative. The tribal chairman instructed the Interagency Coordinating Committee and the director of the Health Authority to investigate and then to compose a proposal for the Phase I Healthy Nations Program.

Phase I:

This steering committee invited key stakeholders and management personnel of other tribal agencies to participate in work sessions to compose the proposal. The formation of the guiding principles centered on concepts taken primarily from Apache tradition. Using the images of the Apache Warrior and the Changing Woman (a female figure ceremonially transforming into a woman), the committee decided that the cardinal healing philosophy would be centered on traditional beliefs and spirituality. They concluded that these components of the Apache life were underrepresented in the current array of services and community activities and that they constituted a match for the Healthy Nations mission and objectives. The committee aptly named their Healthy Nations program “N’dee Benadesh,” which means “the People’s Vision.”

The committee submitted the proposal outlining an extensive grassroots action plan utilizing cluster groups to solicit ideas and volunteers to manage the

prevention and early intervention activities and goals. Many steering committee members transformed into the leaders of the cluster groups and also constituted the Healthy Nations advisory committee. The director of the Tribal Health Authority was to be the coordinator of “N’dee Benadesh”. The proposal was favorably reviewed and the White Mountain Apache tribe received the grant for Phase I planning and development of Healthy Nations.

Immediately, the director of the new Healthy Nations program convened meetings with existing cluster groups and initiated development of the others. A total of twelve cluster groups—representing women, men, youth, parents, elders, and educators, among others—began holding bimonthly meetings with the staff of Healthy Nations. “N’dee Benadesh” provided materials and supplies, including food, for the cluster groups, demonstrating the flexibility of the grant funds. This ability garnered attention from other agency directors (many of whom were cluster group leaders) and stimulated a subtle posturing to gain access to the funds for individual program enhancement. The cluster group format produced anticipated results, generating ideas and activities salient to the four grant requirements.

The grant administration was located within the Health Authority. This was a strong position providing access and support to Healthy Nations. Further evidence of tribal support for the program came as the tribal council endorsed a two-hour per week absence from their regular job responsibilities for those Healthy Nations cluster group members. This commitment fueled the growth and expansion of Phase I pilot programs.

A public awareness campaign focusing on the goals and vision of “N’dee Benadesh” commenced immediately. The program utilized the tribal radio station and created the Healthy Nations newsletter. A weekly hour-long program on the radio highlighted upcoming activities, cultural topics, and strong anti-substance-abuse messages. Combined with easy listening Native American music, this medium reached approximately 90 percent of the households on the reservation. The success of the radio program prompted the planning for a youth talk show. The newsletters contained inspirational stories, vital community information, and a schedule of Healthy Nations activities. The purposeful use of culture even informed the layout and column titles of the newsletter. The vision to revitalize and reconnect to the historical roots of the community was strong.

Other activities formulated by the cluster groups included women’s, youth and men’s conferences. Fifteen inspirational speakers, chosen through community and participant inquiry, offered insight into being healthy, avoiding substances, and finding pride in being Native. The gathering of women included themes around parenting, supporting recovery in the community, and traditional roles and wisdom available to them. When the youth were surveyed about speakers they wanted for their conference—given the choice among famous sport figures and nationally known celebrities—their overwhelming response was to see the local Apache Hotshot and other local heroes. This preference guided the reconnection of youth with the elders and adults throughout the rest of the program. The men’s conference drew the least participants, but still informed the “N’dee Benadesh” staff about issues important to this group.

Other activities were more uneven and demonstrative of the context of Healthy Nations. The choice of the program logo served as an example of activities that produced tension at that time and also depicted a constant stress throughout the life of “N’dee Benadesh.” Consensus on what represented the traditional qualities and customs to be depicted was never achieved. Different interpretations, including the infiltration of non-Native religious ideas, marked the negotiations and development of the logo to represent the vision of Healthy Nations. A compromise unfolded culminating in a logo with many symbols of Apache nationhood and lifestyle while avoiding the more ceremonial and spiritual-natured representations.

Phase I saw the initiation of numerous activities addressing prevention and treatment enhancements. Some of these activities included adventure camps and treks, in-school curriculum that focused on traditional ways, story telling with puppets to educate pre-schoolers, and an environmental rehabilitation project for youth called “Challenge to Change.” These successes were carried into the next phase. One well-intended project that did not succeed was the centralized computer database project, envisioned as a method for coordinating and facilitating early identification and referral services for youth and adults struggling with problems. The idea fell victim to memories of breached confidentiality among service providers, resistance to disclosures, and lack of sufficient funding and manpower. After seeking consultation from the NPO and other tribal representatives, this program was dissolved. Other mechanisms for

referrals and coordination would have to be entertained in the later Phase II grant.

Transition:

A retreat for the Healthy Nations staff and advisory committee convened just prior to submission of the Phase II proposal. An opportunity to measure their successes and plan for the next four years topped the agenda. The current “N’dee Benadesh” director and staff had been enjoying a strong relationship with the cluster groups and had managed to develop a network of community volunteers. So there was some surprise when tribal leadership instituted a significant change in the leadership matrix of the program. Corresponding to a tribal election and change in overall tribal leadership, the shift in leadership diminished the role of Healthy Nations and disrupted its smooth development and direction. This transition period lasted approximately one year, generating a more halting and uneven program trajectory. The original director was reassigned and other Healthy Nations staff were given different job responsibilities. Notwithstanding the changes in leadership and the loss of momentum, the basic structure of the cluster group organization and the focus on traditional activities survived into Phase II. The site visit from the NPO during this period was seen as supportive but conveyed deep concern about the loss of momentum and association with the Phase I successes, goals, and objectives.

Phase II:

Early Phase II was defined as a regrouping period followed by turbulence and change. This pattern existed through the first two years of Phase II. Some of the objectives and goals were left unattended or delayed as each new leadership group established working relationships with different project leaders and gained deeper understanding of grant maintenance requirements only to leave the program. Correspondingly, a fluctuation in the composition of tribal leadership and subsequent change in support and alliances created a period of day-to-day operational challenges. The conferences continued although the men's conference diminished in scope and success. The public awareness campaigns remained active, and the youth talk program commenced. The pre-school cluster group dissolved when two skilled members moved out of the area and the program was unable to continue. Some cluster groups were integrated into larger cluster committees, eventually leaving eleven groups, three of which were comprised of remnants of two original clusters. Agency directorships changed and, therefore, altered the composition of the cluster groups and the advisory committee. After two years of starts and stops including four different "N'dee Benadesh" directors and numerous program coordinators, the original director was once again leading the program. This signified the final direction and iteration of the Healthy Nations program.

The grassroots model had served its role well particularly through the first two years of Phase II. The media program that was slated to create videos and public service announcements had withered due to loss of supportive adjunct

funding and diminished attention. Other aspects of public awareness remained healthy and were expanded through community surveys and participation. School-based programs, particularly the cultural curriculum, were still active and would gain momentum in the last two years.

Youth activities were beginning to gain strength and focus. The Adventure Team cluster had forged a strong relationship with the Rainbow Treatment center. One successful project was the Ropes Course. The activities and challenging tasks developed in this program taught the young people skill, confidence, and teamwork. It was recognized as a positive alternative to the lassitude of the youth and a strong element in treatment-based programming. The combination of enhanced Rainbow Center with the Ropes Course, which was now accommodating off-reservation groups due to its popularity and success, provided more targeted options for treatment and aftercare. Traditional activities and culture had become more identifiable in the community. “N’dee Benadesh” had empowered the community to take voice and action to combat the negative effects of substance abuse. Those leaders and volunteers who gathered together to sponsor prevention events learned to engage the youth, set aside differences in a common cause, and persist in the face of an ever-changing political climate.

Highlights:

The concept of infusing more culture and tradition into the activities and lives of tribal members is a significant attribute of “N’dee Benadesh.” The

development and maturation of this vision and attendant objectives are remarkable. With competing spiritual ideas as well as the diffuse nature of the communities, the emergence of traditionally informed and maintained programming speaks powerfully about the central role of historical identity and ceremony. The icons and symbolisms taken from Apache culture, especially the Warrior and the Changing Woman, depict the tenacity and commitment of the cluster groups and community members in the war against alcohol. Today, the conferences continue with women gathering by the hundreds to support each other and nurture the health of their families and, therefore, the Apache nation. The youth are better connected to each other, the land, and their Native identity. The youth conference is now sponsored by other tribal entities and schools. Cultural curricula and prevention messages are still played on the radio and found on signs leading into Whiteriver. Members of the council still recall the flexibility of the grant and it's enabling them to do what they needed to help the community. Healthy Nations still has presence as a movement of collaboration and cultural acknowledgement.

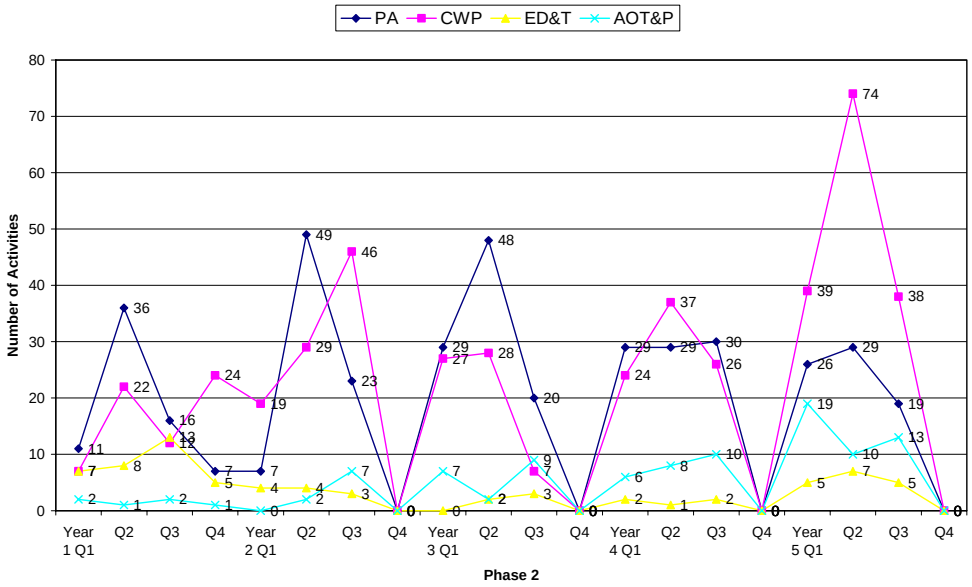
The Ropes Course, among the many positive youth programs, deserves recognition. Constructed to augment treatment and aftercare programming, the concepts and activities taught during this course became so widely known for their success and effectiveness that other at-risk youth and adults, outside groups, and business concerns utilized the facility. The Ropes Course director formed caring relationships and provided opportunities to explore trust, team work, and success through individual and team effort. It is reported that many

youth, now young adults, have commented on the personal impact of this component of the White Mountain Healthy Nations program. The trek, Apache Adventures, and “Challenge to Change” all represent vital ideas and activities that produced good results. Although the Ropes Course currently sits abandoned, talks are underway to revive it and reawaken the spirit of success it represented. Some of the other youth ventures have been assumed by private individuals or communities. Although not institutionalized in the formal sense, these programs remain in effect in the tribal treatment programming and inform new ventures and projects.

Tradition holds that to fully recognize the strength of the Apache way of being, a trip to Mount Baldy was necessary. One unheralded but powerful activity sponsored by “N’dee Benadesh” was just that—a trip to Mount Baldy. The community outreach effort discovered that many tribal members had never completed this proving trek. The staff therefore saw an opportunity to join the community and arranged and conducted hikes and camps to Mount Baldy. The “vision quest” intent of these hikes provided a deepened respect for the traditional ways and a renewed connection to the earth. Teaching opportunities with elders and traditional members expanded the consciousness of the values and ceremonies needed to live a healthy life and succeed in the two worlds—traditional and modern—of the American Indian. These hikes continue today. Groups are guided by those who participated with Healthy Nations. The power and healing of the land has returned for those who have discovered this life force.

Lastly, the core staff and leadership, including the original advisory and tribal council members, remain in the community. Although working in different agencies and toward different goals, the philosophy and community-based model of initiating action and change on the reservation still informs policy and program. The treatment center continues with culturally based and culturally sensitive and specific interventions. The aftercare facility and staff are reported to utilize the information and programming developed through Healthy Nations. The mobilization and growth of "N'dee Benadesh," through struggles and change, demonstrated an ability to continue on and strengthened staff resolve and commitment. The movement of Healthy Nations still functions in the background of the ongoing war on substance abuse on the White Mountain Apache Reservation.

White Mt. Apache Activities



Key: **PA = public awareness**
CWP = community-wide prevention
ED&T = early identification and treatment
AOT&P = accessible options for treatment and relapse prevention

Quantitative

Comparisons and Evaluations:

Eight-site Comparison

HEALTHY NATIONS INITIATIVE EVALUATION

Quantitative Component

The Healthy Nations Initiative: What It Was

The Healthy Nations Initiative (HNI) was created to help American Indians and Alaska Natives reduce the harm caused by substance abuse. It got underway during the early- and mid-1990s at fifteen sites (ultimately fourteen sites). These sites were located on Indian reservations, in large cities, and on tribal trust lands. Tribal health departments and their health promotion and disease prevention programs, urban Indian health centers, and not-for-profit organizations that served Indian people were the most common organizational units that administered Healthy Nations. Simply put, the Healthy Nations Initiative provided money, through grants, to support the development of community-wide efforts to combat substance abuse through efforts that integrated

- public awareness campaigns;
- prevention programs; and
- services for treatment, aftercare, and support.

A great deal of emphasis was placed on the early identification of and prevention of alcohol abuse, illicit drug use, and cigarette smoking. The active use of cultural activities and the incorporation of traditional cultural values throughout every aspect of all Healthy Nations projects were key components of the Initiative.

The HNI was a six-year, two-stage competitive program with a total funding level of $13.5 million. During the first stage, two-year development and

feasibility grants of up to $150,000 each were provided to fifteen tribes and community organizations. All grantees successfully completing the first stage then received four-year implementation grants of up to $1 million each.

Underwritten by the Robert Wood Johnson Foundation the Healthy Nations Initiative was intended to complement ongoing efforts of numerous organizations whose purpose was to address and reduce the harm caused by substance abuse among American Indians and Alaska Natives. These organizations included the Center for Substance Abuse Prevention, the Indian Health Service, state and local government programs, and not-for-profit organizations.

The goal of the initiative was to demonstrate that tribes and communities can, over time, achieve substantial reductions in the demand for—and consequently the use of—alcohol and other harmful substances, including tobacco and illicit drugs.

In order to realize this goal, grantees were expected to conduct the following activities which, in essence, became their major objectives:

1. To implement a public awareness campaign designed to generate broad-based tribal and community support for efforts to reduce demand for tobacco, alcohol, and illicit drugs;
2. To install a multifaceted, community-wide prevention effort targeted especially at children and adolescents that could, for example, include (a) prevention programs in the schools, as well as in community settings; (b) development of recreational and cultural activities promoting self-

esteem; and (c) prevention training for teachers, health care workers, and others;

3. To identify or create and implement special programs to promote early identification and treatment of substance abuse among youth and other high-risk tribal members, such as pregnant women; and
4. To identify and promote a range of accessible options for substance-abuse treatment and relapse prevention as well as for outreach to families of people with substance-abuse problems.

Although these were the objectives of full-fledged grantee programs, grantees were also required to do some important preparatory work prior to receiving the implementation grant award. During the initial twenty-four-month developmental/ feasibility phase, grantees were expected to

- document the current magnitude of the substance-abuse problem as it affected various segments of the tribe or community;
- identify and pilot-test segments of the proposed interventions including, as appropriate, traditional cultural approaches;
- develop collaborative arrangements with other organizations and government entities;
- determine the feasibility of implementing a comprehensive, systematic program of prevention, treatment, and relapse prevention within the tribe or community;
- design a public awareness campaign;

- develop a detailed work plan—with clear benchmarks and objectives—for the implementation, coordination, and financing of a comprehensive, community-wide substance-abuse prevention and treatment system; and
- develop a clear strategy for continuing support of the project following the conclusion of Foundation funding.

Grantees that successfully completed the planning phase applied to the Foundation for up to $1 million for four years of project implementation funds. The exact amount of the implementation grant depended on the scope of the project and the number of people to be served.

Describing and documenting how each grantee planned and implemented these activities is an important part of the qualitative component of the Healthy Nations Initiative Evaluation (HNIE). In addition, through personal interviews, open-ended surveys, and other qualitative methods, the HNIE is interested in learning about

- Grantee community perceptions of their ability to successfully address the harmful effects of substance abuse;
- Grantee community attitudes toward prevention methods and programs;
- Grantee community perceptions of their success at community organization and mobilization;
- Grantee community perceptions of whether or not there have been improvements in the demand for and use of alcohol, illicit drugs, and cigarette smoking; and

- Grantee responses to the question, "What difference did your Healthy Nations Program make?"

The Healthy Nations Initiative: What it Was Not

The Healthy Nations Initiative was not a research program study. The Initiative never specifically intended to rigorously measure changes in the demand for or the use of alcohol, illicit drugs, or cigarettes. For that reason, no baseline measures of alcohol, illicit drug, or cigarette use were taken for the purpose of either empirical research or evaluation. Nor were there any other empirical measures or tests utilized to determine whether or not demand for the use of harmful substances went down as a result of HNI interventions. Other than processing information, such as the numbers of people who attended or participated in Healthy Nations activities, no primary outcome indicator data were generated by the grantees. Because it was not a research study and because the plan for evaluation was developed well after the Initiative began, the opportunity was lost for measuring and thereby establishing cause and effect between reduced demand and use of harmful substances and the interventions of the HNI.

We, therefore, had to consider less rigorous methods for the quantitative component of the HNI evaluation. We found one that—while it cannot address the issue of cause and effect—can tell us something about the relationship between HNI activities and reduced demand for harmful substances in some American Indian and Alaska Native communities.

Social Indicator Analysis

The original aims of the quantitative component of the HNIE were

- to identify, compile, and analyze substance abuse Outcome Indicators; and
- to iIntegrate grantee program descriptions and Outcome Indicators.

Outcome indicators are used to measure program performance. But, as noted, no primary outcome indicator data were required or generated by the grantees. In the absence of specific and pre-determined program outcome indicators and specific pre- and post-program methods for measuring them, the HNIE quantitative team focused on selected secondary information sources, called social indicators.

Our intentions were to use social indicators

- to augment the qualitative component of the HNIE by using social indicators to identify alcohol and harmful-substance use trends in grantee communities; and
- to do this by placing social indicator information within the context of each grantee program description.

In recent years, the use of social indicators in this manner has become fairly widespread. Both the National Institute of Drug Abuse's (NIDA) Division of Epidemiology and the Substance Abuse and Mental Health Service Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) promote the use of social indicators for

- assessing drug abuse within and across communities; and

- employing Multiple Indicator Analysis, a methodology for using secondary data to analyze illicit-drug use.

Four sources of social indicator information were chosen for the HNIE:

1. National and, where available, individual State Youth Risk Behavior Survey (YRBS) data on tobacco, alcohol, and illicit-drug use.
2. Local law enforcement data such as alcohol-related arrests, accidents, injuries, and deaths.
3. School data such as grade-point averages, dropout rates, and participation in school activities.
4. Tribal and Indian Health Service (IHS) data such as alcohol and drug-related hospitalizations and outpatient visits.

Our experience collecting social indicator information from grantee communities proved to be most interesting and at times quite challenging. Additionally, it has been a learning experience whose lessons we are sure will help inform future initiatives in Indian country. I also wish to acknowledge the generous assistance of former HNI directors, staff at the Indian Health Service, Information Technology Support Center, tribal and community law enforcement officers, and school officials.

The following seven grantees participated in the quantitative component of the HNIE:

- Confederated Salish and Kootenai of the Flathead Reservation
  St. Ignatius, Montana
- Confederated Tribes of the Warm Springs Reservation
  Warm Springs, Oregon

- Northwest New Mexico Fighting Back
  Gallup, New Mexico

- Norton Sound Health Corporation
  Nome, Alaska

- United Indian Health Services, Inc.
  Eureka, California

- Minneapolis American Indian Center
  Minneapolis, Minnesota

- Seattle Indian Health Board
  Seattle, Washington

SURVEY DATA

Although national population surveys are very useful for setting policy and examining overall trends, they may not assess the drug use of special segments of the population. Rural youth, for example, may form too small a part of a national probability sample to provide useful data. Minority groups may not be adequately represented, and school-based surveys will miss absentees and dropouts (Beauvais, 1996).

One of the most intractable problems American Indian researchers ever face is the absence of valid and reliable, longitudinal survey information. In most published national surveys, seldom is the American Indian population even considered for representation. While this has been a chronic problem, well known for years, even to this day major surveys of American youth do not include adequate numbers of American Indians to produce useful data. These important national surveys include the following:

- Monitoring the Future (MTF) a national survey that tracks drug-use trends and related attitudes among America's adolescents. This survey is conducted annually by the Institute for Social Research at the University of Michigan with support from the National Institute on Drug Abuse (NIDA).
- Partnership Attitude Tracking Study (PATS) is an ongoing national research study that tracks drug use and drug-related attitudes among children, teenagers, and their parents. It is sponsored by the Partnership for a Drug Free America (PDFA).

- The National Survey of Parents and Youth (NSPY) is sponsored by the National Institute on Drug Abuse (NIDA) to evaluate the Office of National Drug Control Policy's (ONDCP's) National Youth Anti-Drug Media Campaign.

Two other national youth surveys have, however, managed to include sufficient numbers of American Indian youth on a regular, annual basis so that, at least in some cases, useful data may be provided for several years. These surveys are the following:

- **The Youth Risk Behavior Survey (YRBS)** is a component of the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (YRBSS). The YRBS biennially measures the prevalence of six priority health risk behaviors including alcohol and drug use. The YRBS includes national, state, territorial, and local school-based surveys of high school students. However, only a few states adequately represent American Indian and Alaska Native youth in their survey sample.
- **The National Household Survey on Drug Abuse (NHSDA)** is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). In its most recent form, the 1999 and 2000 data are based on information obtained from approximately 70,000 people aged twelve or older. The survey collects data by

administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

Before taking a look at the results of these surveys, however, I will mention two researchers who are among the first and foremost to conduct national, annual surveys of American Indian youth and their self-reported use of cigarettes, alcohol, and illicit drugs—E.R. Oetting and Fred Beauvais. In 1996, Beauvais reported trends in drug use among American Indian students and dropouts for the period 1975 to 1994. While it is a challenge to draw a representative sample of American Indian and Alaska Native (AI/AN) youth, Drs. Oetting and Beauvais have successfully done so with far fewer resources than the sponsors of the aforementioned surveys. As with all things, it is a matter of will, and strength of will is often heavily influenced by a judgment of relative importance. Bluntly stated, the health of AI/AN youth, in particular, and AI/AN people, in general, has not been of great importance to our government and our society.

Perhaps the most recent example to which I refer was an amendment to a budget resolution considered by Congress for additional funding for the Indian Health Service for the fiscal year 2005 budget, introduced by Senator Tom Daschle, D-S.D., and defeated on a party line vote.

"The health care currently provided by the Indian Health Service is so inadequate that Native American men, women, and children are routinely denied even the most basic medical care that most of us take for granted, in many cases, would consider essential," Senator Daschle said.

For the general U.S. population, health care spending is at the rate of $4,400 per person. In Indian country the spending is at $1,800 per person. More is spent for Medicare, Medicaid, and other beneficiaries by the federal government. It has been established in numerous studies that American Indians and Alaska Natives must endure the consequences of the lowest health status of any group of Americans. Substance abuse, including alcohol and illicit drug use, is one of the most serious health problems among American Indians and Alaska Natives (Office of National Drug Control Policy Report). Some examples follow:

- American Indian/Alaska Native youth aged 12-17 were more likely than youth from other racial/ethnic groups to smoke cigarettes during the past month.
- Among Blacks, Hispanics, Asians, and American Indians, American Indians had the highest rate of underage, past-month alcohol use. (Among all groups, Whites had the highest rate of underage, past-month alcohol use.)
- American Indians/Alaska Natives had the highest past-month drug use for all drug categories with the exception of alcohol use. Current illicit-drug use (past-month) for American Indian/Alaska Native youth aged twelve and older was 10.6 percent in 1999.
- Among youth aged 12-17, American Indians/Alaska Natives had the highest rate of current use of illicit drugs (almost 20 percent).
- Death rates from alcohol-related causes were more than three times higher for American Indians/Alaska Natives than for other groups.

American Indians/Alaska Natives had higher rates of suicide, homicide, and unintentional injuries or accidents, most of which were related to alcohol.

- Although figures on drug use vary greatly from tribe to tribe, statistics show marijuana as the second most widely used drug after alcohol. Over one-half of all American Indian/Alaska Native youth had tried marijuana. On some reservations the level was much higher, while the rates for the general youth population were significantly lower—only 22 percent of all youth reported having tried marijuana.
- The rate of current hallucinogenic use among youth aged 12-17 was also the highest among American Indians/Alaska Natives (3.7 percent) and lowest among African Americans (0.2 percent).
- American Indian/Alaska Native youth reported substantially higher lifetime drug use for marijuana, cocaine, stimulants, and psychedelics than all other racial/ethnic groups.
- American Indians/Alaska Natives made up less than 1 percent of the U.S. population in 1999, yet they accounted for 2.4 percent of all admissions to publicly funded substance-abuse treatment facilities.

Between 1974 and 1994, Dr. Beauvais conducted annual surveys of American Indian youth and reported on their lifetime use of drugs including alcohol, marijuana, inhalants, cocaine, stimulants, psychedelics, and cigarettes. The trend lines he prepared for both AI/AN and non-Indian youth clearly show that there was a dramatic increase in marijuana use from 1975 to 1980 and

thereafter a modest decline in use until 1992. Another notable pattern was the "consistent, exceptionally higher rate of marijuana use among Indian youth." The higher rate of marijuana use is also conspicuous in and consistent with data from the National Household Survey on Drug Abuse.

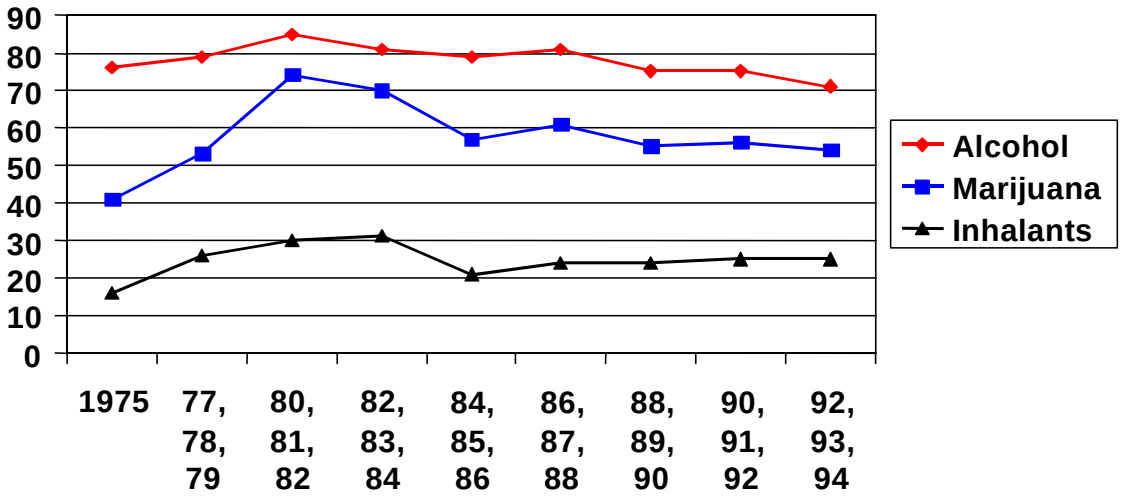
In the surveys conducted by Dr. Beauvais, rates for AI/AN youth lifetime use of marijuana ranged from 41 percent (1975) to 74 percent (1980). During the early 1990s, the rates were about 55 percent. In 1992 the rates were 53 percent for AI/AN youth and 11 percent for non-Indian youth.

For lifetime alcohol use, the AI/AN rates ranged from 71 percent (1994) to 85 percent (1981 and 1982). Lifetime alcohol rates during the early 1990s ranged between 71 and 75 percent.

The trend for lifetime use of inhalants ranged from 16 percent in 1975 to a high of 31 percent in the early 1980s. During the early 1990s, the rate was steady at about 25 percent. (See Figure 1.)

Figure 1 - American Indian Student Lifetime Use of Alcohol, Marijuana, and Inhalants, 1975-1994

Adapted from "Trends in Drug Use among American Indian Students and Dropouts 1975-1994" by Frederick Beauvais, Ph.D., *Am J Public Health*, 1996;86:1594-1598



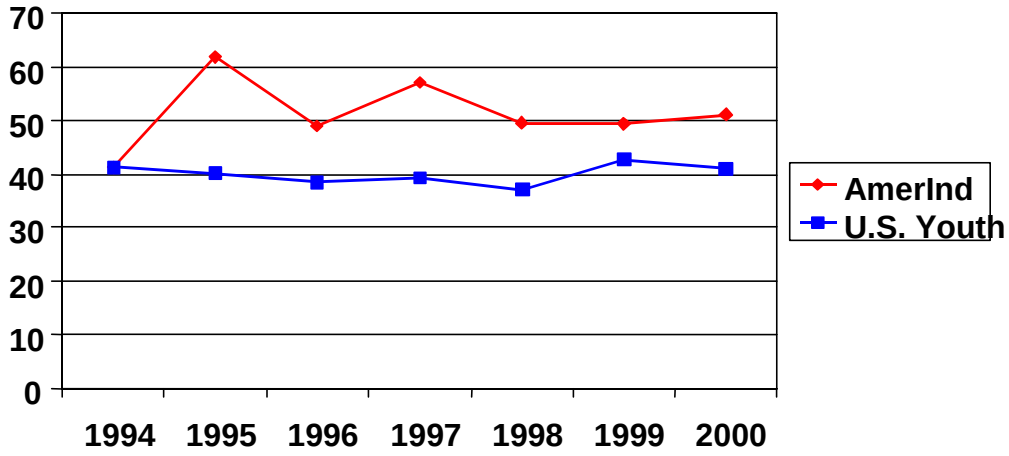
National Household Survey on Drug Abuse (NHSDA). American Indian youth trend data from the NHSDA for the period 1994 to 2000 include

- Lifetime use of alcohol, age 12-17
- Lifetime use of alcohol, age 18-25
- Lifetime use of marijuana, age 12-17
- Lifetime use of marijuana, age 18-25

On the average, for all U.S. youth aged 12-17 years, between 1994 and 2000 about 40 percent reported lifetime use of alcohol (range 37.2% to 42.7%). For American Indian youth, on the average, over 51 percent reported lifetime alcohol use (range 41.2% to 61.8%). The overall trend for U.S. youth was down between 1994 and 1998, rising in 1999 and falling in 2000. The overall trend for American Indian youth from 1994 to 1998 had risen and fallen each year. Since

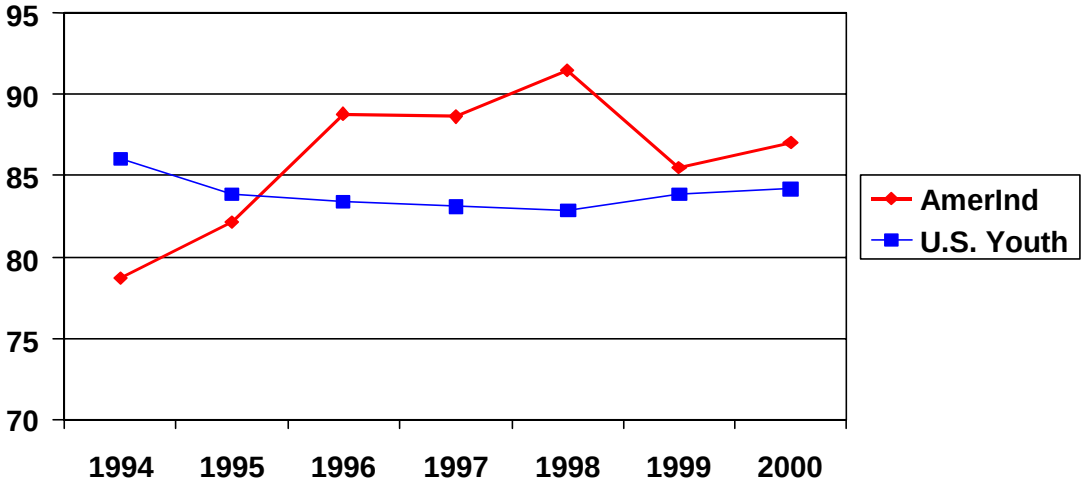
1998 the trend has not varied by much although there was an increase between 1999 and 2000. (See Figure 2.)

Figure 2 - Lifetime Use of Alcohol, American Indian and All U.S. Youth Ages 12-17, 1994-2000
National Household Survey on Drug Abuse (NHSDA)



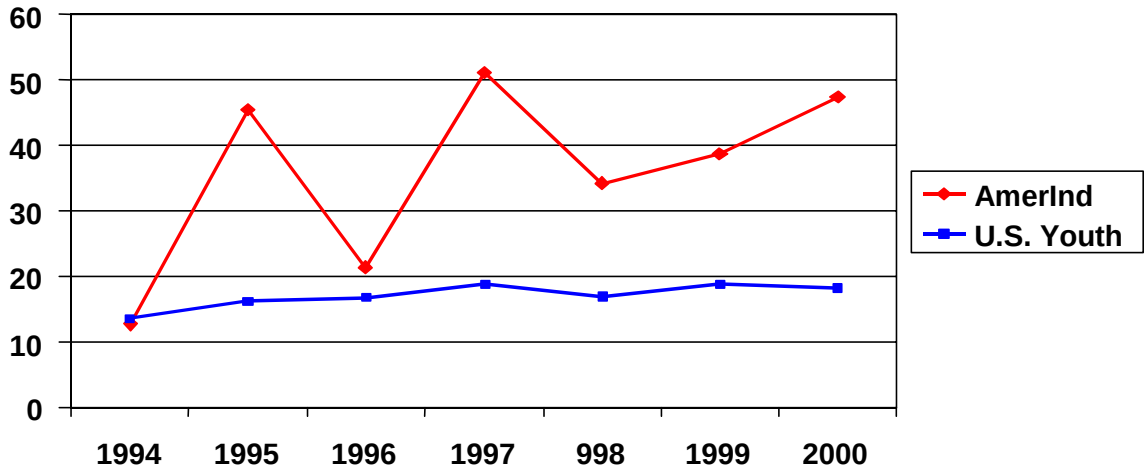
For the age group 18-25 years, the difference between American Indian youth and U.S. youth is not as great. In fact, on the average they are similar—86 percent and 84 percent, respectively. The overall trend for 18-25-year-old American Indian youth was up from 78.7 percent in 1994 to 87 percent in 2000. The overall trend for U.S. youth has been, for the most part steady and slightly down from 86 percent to 84 percent. (See Figure 3.)

Figure 3 - Lifetime Use of Alcohol, American Indian and All U.S. Youth Ages 18-25, 1994-2000
National Household Survey on Drug Abuse (NHSDA)



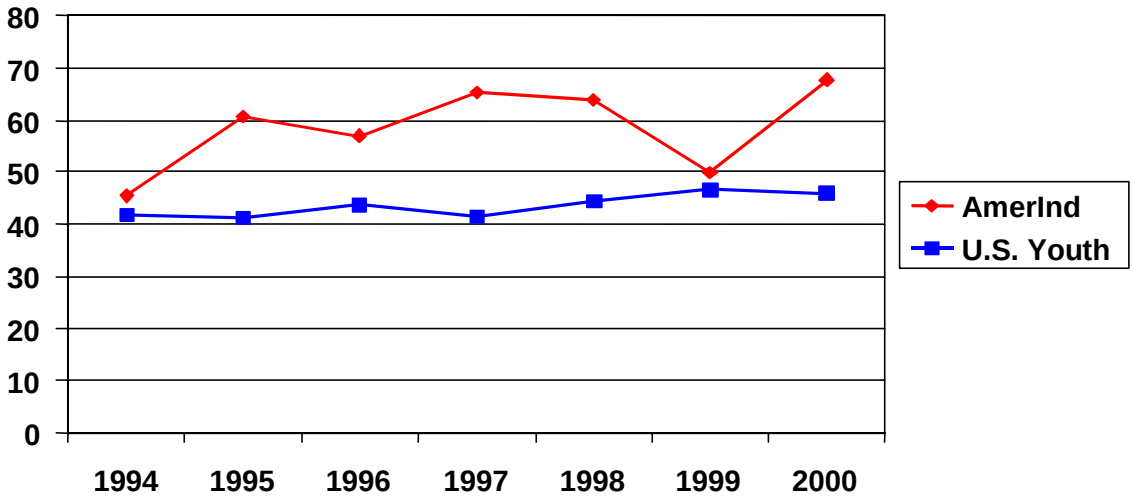
Self-reported lifetime marijuana use among American Indian youth aged 12-17 years is much higher than that of all U.S. youth. The trend data from NHSDA show a sharp upward trend, especially since 1998. Between 1994 and 1997, the trend in lifetime marijuana use rose and fell sharply—from about 13 percent to about 51 percent. The trend fell to 34 percent in 1998 but rose steadily since then to 47.4 percent in 2000. For U.S. youth the overall trend in lifetime marijuana use was up from about 14 percent in 1994 to about 18 percent in 2000. The difference between American Indian and U.S. youth is most striking for this age group and this drug. (See Figure 4.)

Figure 4 - Lifetime Marijuana Use, American Indian and All U.S. Youth ages 12-17, 1994-2000
National Household Survey on Drug Abuse (NHSDA)



The overall trend in lifetime marijuana use among American Indian youth aged 18-25 was up from 45.5 percent in 1994 to almost 68 percent in 2000. The overall trend for U.S. youth was up from about 42 percent in 1994 to about 46 percent in 2000. On the average, for the trend period 1994 to 2000, 58.5 percent of American Indian youth and 43.6 percent of U.S. youth reported lifetime marijuana use. (See Figure 5.)

Figure 5 - Lifetime Marijuana Use, American Indian and All U.S. Youth Ages 18-25, 1994-2000
National Household Survey on Drug Abuse (NHSDA)



Youth Risk Behavior Survey (YRBS). In 1994, 1997, and 2001 the Bureau of Indian Affairs used the YRBS instrument to survey all 9th and 12th graders enrolled in Bureau-funded schools. The YRBS was developed by the Centers for Disease Control and Prevention, and they have used it to conduct a national survey every two years since 1991 in over 100 selected public high schools across the country. As noted earlier there has been a consistent problem with the statistical reliability of the sample because there have been so few American Indian students surveyed. This problem has been somewhat allayed by the survey of BIA students and by at least one statewide survey (Montana) that included enough American Indian students in its sample to produce useful information. The report on the findings of the BIA-YRBS indicates that the YRBS, conducted solely with American Indian students, can be used as a reliable

source of information for schools and communities that wish to address violence and substance-abuse prevention programs.

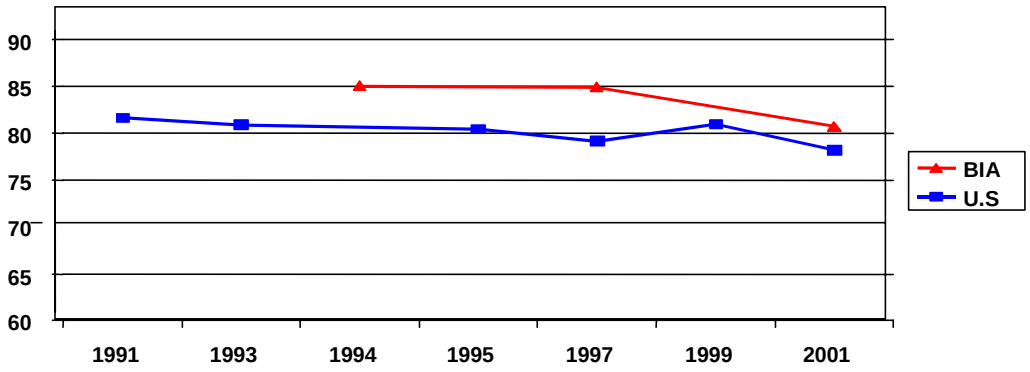
American Indian student trend data from the YRBS for the period 1994 to 2001 include

- lifetime alcohol use
- current alcohol use
- episodic heavy drinking
- lifetime marijuana use
- current marijuana use
- lifetime inhalant use

Trends in each of the above parameters, except for current marijuana use and lifetime inhalant use closely parallel U.S. student trends. However, American Indian student trends also show consistently higher levels of use than that of U.S. students.

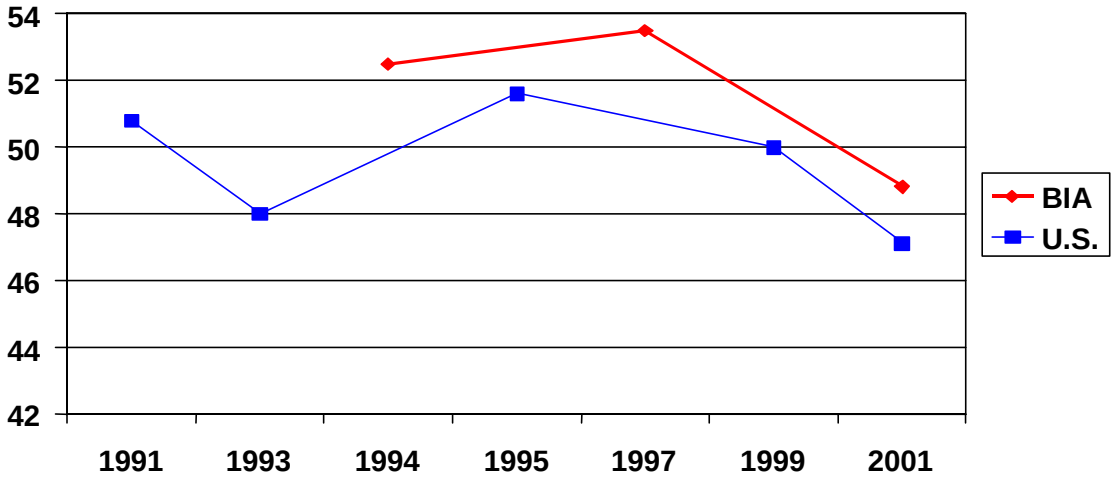
Overall trends in lifetime alcohol use are similar for both American Indian and U.S. students. The trend is down for both groups, falling from 85 percent to about 81 percent for American Indian students and falling from about 82 percent to 78 percent for U.S. students. (See Figure 6.)

Figure 6 - Lifetime Alcohol Use
BIA and U.S. Students, 1991-2001
Youth Risk Behavior Survey (YRBS)



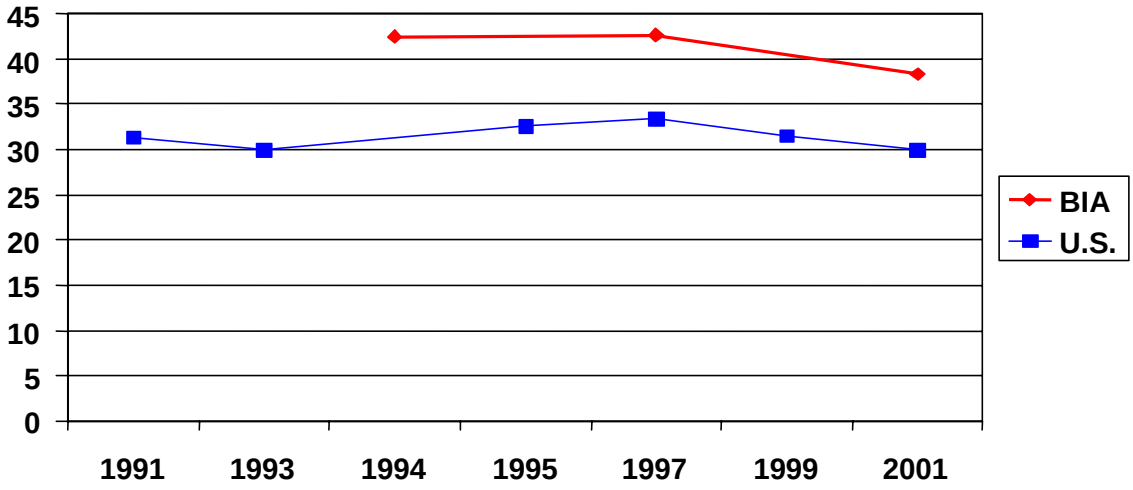
Similarly, the overall trend in current alcohol use is down for both American Indian and U.S. students. The trend fell from 52.5 percent to about 49 percent for American Indian students, and it fell from about 51 percent to about 47 percent for U.S. students. (See Figure 7.)

Figure 7 - Current Alcohol Use
BIA and U.S. Students, 1991-2001
Youth Risk Behavior Survey (YRBS)



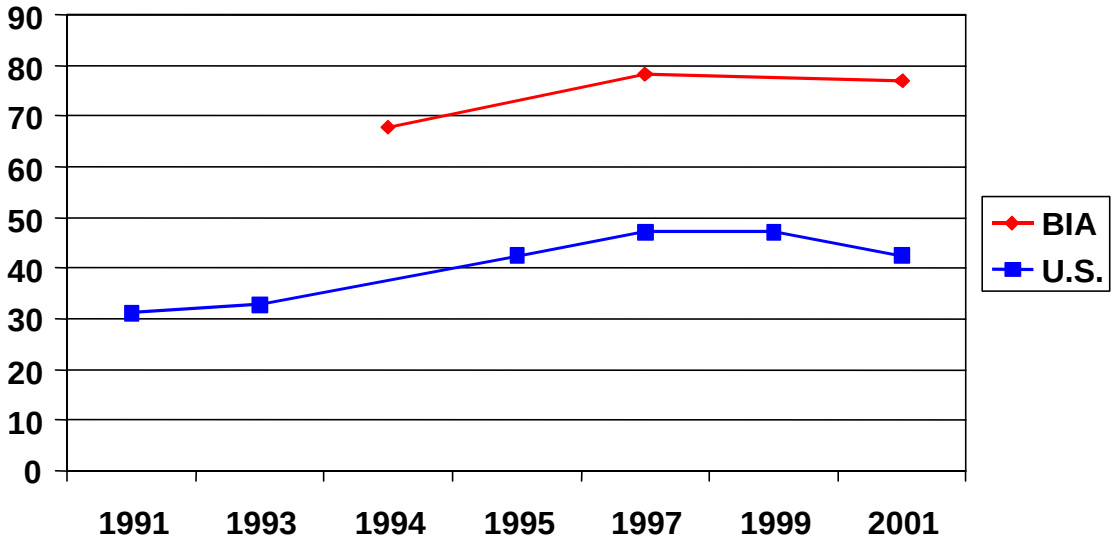
While the overall trend in binge drinking is down slightly for both American Indian and U.S students, there is great difference in their levels of binge drinking. The average proportion of U.S. students who reported binge drinking from 1991 to 2001 was about 31 percent. For American Indian students, the average proportion for the years 1994, 1997, and 2001 was over 41 percent. Nevertheless, both trends fell from 42.5 percent to 38.4 percent and from about 31 percent to 30 percent. (See Figure 8.)

Figure 8 - Episodic Heavy Drinking
BIA and U.S. Students, 1991-2001
Youth Risk Behavior Survey (YRBS)



The average proportion of U.S. students reporting lifetime marijuana use from 1991 to 2001 was about 41 percent. On the average, American Indian students reported lifetime marijuana use at about 74 percent. The difference is striking, and while both trends fell between 1997 and 2001, the change is much more evident for U.S. students than for American Indian students. (See Figure 9.)

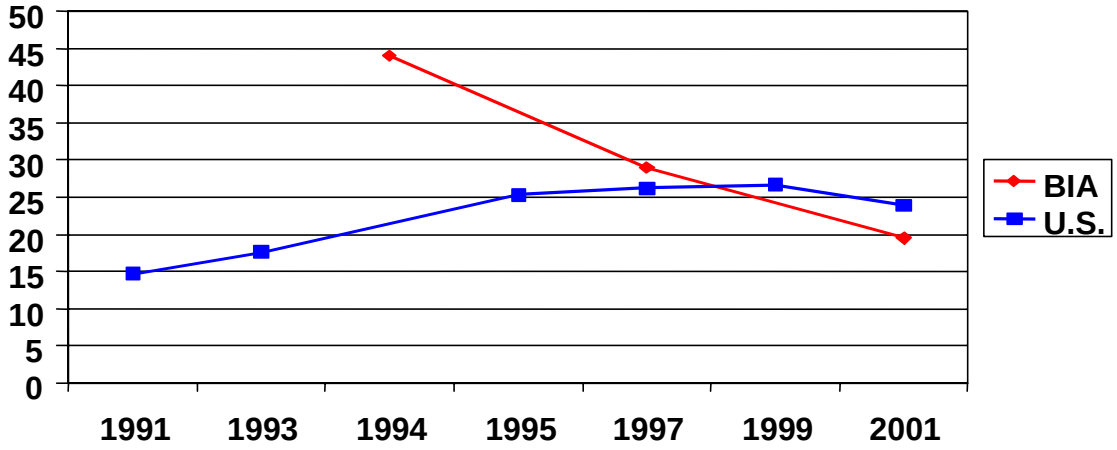
Figure 9 - Lifetime Marijuana Use
BIA and U.S. Students, 1991-2001
Youth Risk Behavior Survey (YRBS)



The overall trend in current marijuana use among U.S. students between 1991 and 1999 was up from almost 15 percent to nearly 27 percent. However, from 1999 to 2001, the trend fell to 19.5 percent.

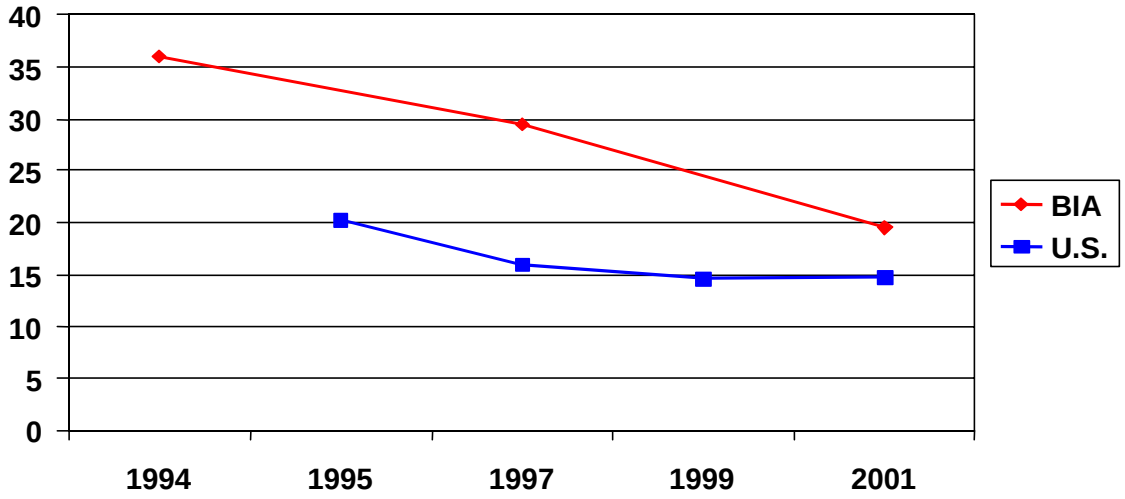
Interestingly, the overall trend in current marijuana use among American Indian BIA students was down sharply—from 44 percent in 1994 to 19.5 percent in 2001. This sharp decline in current marijuana use will be discussed further in the final section of this report, as will the sharp decline in American Indian BIA student lifetime inhalant use. (See Figure 10.)

Figure 10 - Current Marijuana Use
BIA and U.S. Students,1991-2001
Youth Risk Behavior Survey (YRBS)



Overall trends for both BIA and U.S. students were down, especially for American Indian students. In 1994 almost 36 percent of BIA students reported lifetime inhalant use; by 2001 the proportion had fallen to 19.5 percent. Between 1995 and 2001, the proportion of U.S. students reporting lifetime inhalant use fell from about 20 percent to about 15 percent. (See Figure 11.)

Figure 11 - Lifetime Inhalant Use
BIA and U.S. Students, 1994-2001
Youth Risk Behavior Survey (YRBS)



There is no specific health survey trend data on behavioral health or substance abuse for any of the Healthy Nations grantees. However, the states of Montana and Minnesota have included American Indian students in health surveys they conduct on a regular basis. The state of Montana uses the YRBS instrument and surveys American Indian students who live on reservations and American Indian students who live in urban areas. The Salish-Kootenai Reservation is included in this survey. The state of Minnesota administers the Minnesota Health Survey to students, including American Indian students who reside in the Minneapolis-St. Paul metropolitan area.

Montana Youth Risk Behavior Survey. The following information is available from the Montana YRBS for American Indian reservation and urban students for the period 1993 to 2001.

- current alcohol use
- binge drinkers
- lifetime marijuana use
- current marijuana use
- lifetime inhalant use (1995-2001)

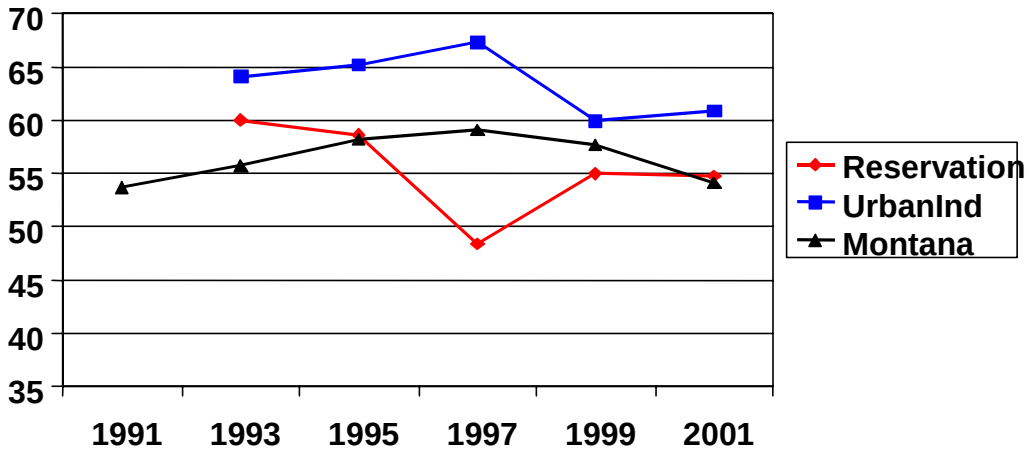
Between 1993 and 2001, the average proportion of American Indian reservation students who reported current alcohol use was about 55 percent (range of 48.4% to 60%). For American Indian students from urban areas in Montana, the proportion was about 57 percent (range of 67.3% to 59.9%). For Montana students in general the average proportion of self-reported current alcohol use between 1991 and 2001 was about 56 percent (range of 53.7% to 59%).

The overall trend for reservation students was down from 1993 to 1997, falling from 60 percent to 48.4 percent. The trend rose in 1999 to 55 percent and fell very slightly to 54.8 percent in 2001.

The overall trend for urban Indian students was up from 1993 to 1997 from about 64 percent to about 67 percent. It then fell to about 60 percent in 1999 before rising to about 61 percent in 2001.

Similarly, the overall trend for Montana students in general rose from about 54 percent in 1991 to 59 percent in 1997. In 1999 the trend fell to 57.6 percent and then to about 54 percent in 2001. (See Figure 12.)

Figure 12 - Current Alcohol Use
American Indian Youth, 1991-2001
Montana Youth Risk Behavior Survey (YRBS)

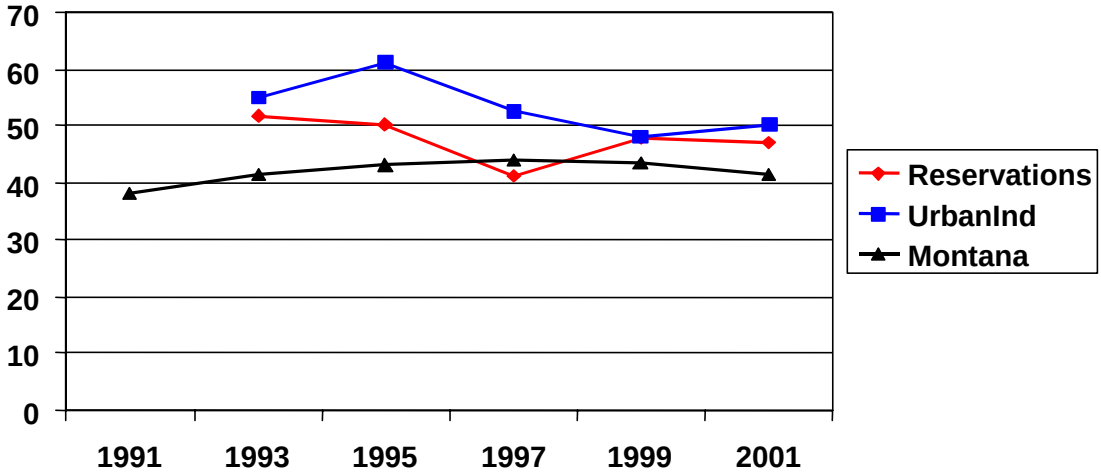


The overall trend in Binge Drinking for Reservation Indian students from 1993 to 2001 was down from about 52 percent at the beginning of the trend period to 47 percent at the end of the trend period. In between the trend fell to its lowest point of 41.2 percent in 1997.

The overall trend for urban Indian students was also down from 55 percent in1993 to about 50 percent in 2001. In between, the trend rose to a high point of about 61 percent in 1995 and fell to its lowest point of 48 percent in 1999.

The overall trend for Montana students in general was up from about 38 percent in 1991 to about 41 percent in 2001, although the highpoint of the trend period was about 44 percent in 1997. (See Figure 13)

Figure 13 - Binge Drinkers
American Indian Youth, 1991-2001
Montana Youth Risk Behavior Survey (YRBS)



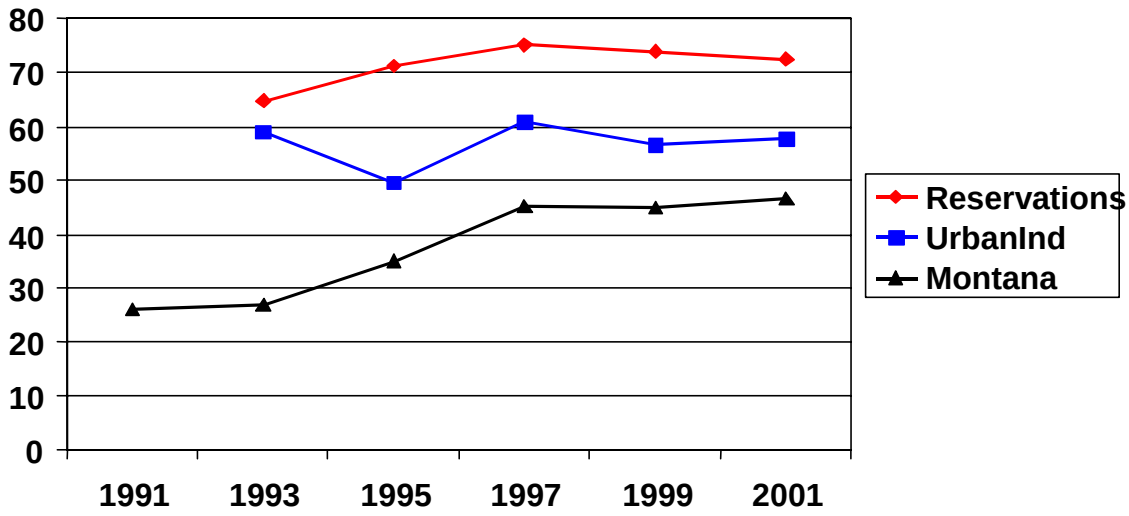
The overall trend in lifetime marijuana use by Indian students who reside on Montana's Indian reservations grew from about 65 percent to almost 73 percent in 2001. The trend reached a high point of over 75 percent in 1997. The average for the trend period was over 71 percent.

The overall trend in lifetime marijuana use by urban Indian students in Montana fell slightly from about 59 percent to about 58 percent in 2001, with a range of about 50 percent in 1995 to almost 61 percent in 1997. The average for the trend period was about 57 percent, 14 percent less than the average for Montana reservation Indian students.

The overall trend for all Montana students between 1991 and 2001 rose dramatically from about 26 percent to almost 47 percent. The trend shows a steady increase over the ten-year trend period. The average for the period was about 37 percent, 34 percent less than the average for Montana reservation Indian students.

In 2001 the proportion of Montana reservation Indian students who reported lifetime marijuana use was over 25 percent greater than that of non-Indian Montana students. (See Figure 14.)

Figure 14 - Ever Used Marijuana
American Indian Youth, 1991-2001
Montana Youth Risk Behavior Survey (YRBS)

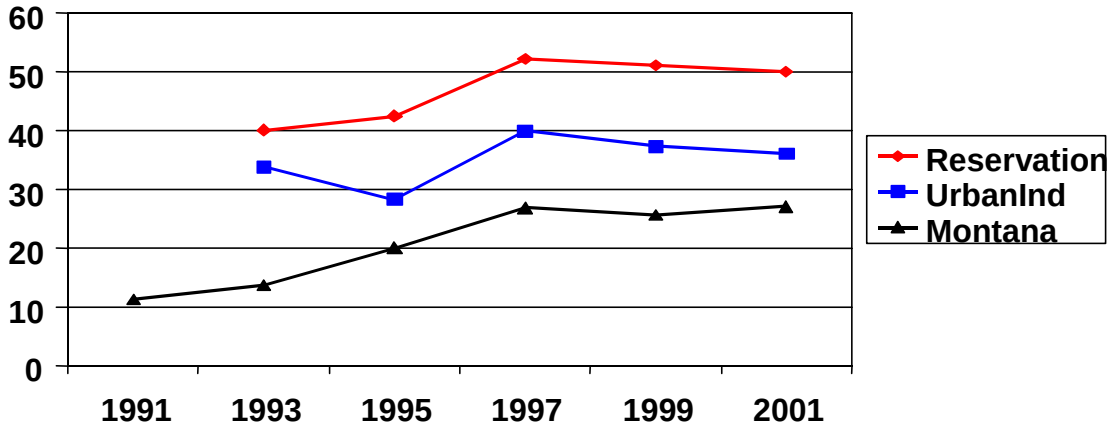


The overall trend in current marijuana use for Montana Indian and non-Indian students is up. For Montana's non-Indian student population, the trend grew from about 11 percent in 1991 to about 27 percent in 2001. The high point during the trend period was about 27 percent in 1997. The average for the period was about 21 percent.

The overall trend for urban Indian students was also up from about 34 percent in 1993 to about 36 percent in 2001. The trend's highpoint was 40 percent in 1997. The average for the period was about 35 percent—14 percent higher than that of Montana's non-Indian students.

Of the three groups of students, reservation Indian students had the highest level of current marijuana use over the period 1993 to 2001. The average level of current marijuana use was about 47 percent, with a range of about 40 percent in 1993 to about 52 percent in 1997. The average was higher than that of urban Indian students and over 25 percent higher than that of Montana non-Indian students. (See Figure 15.)

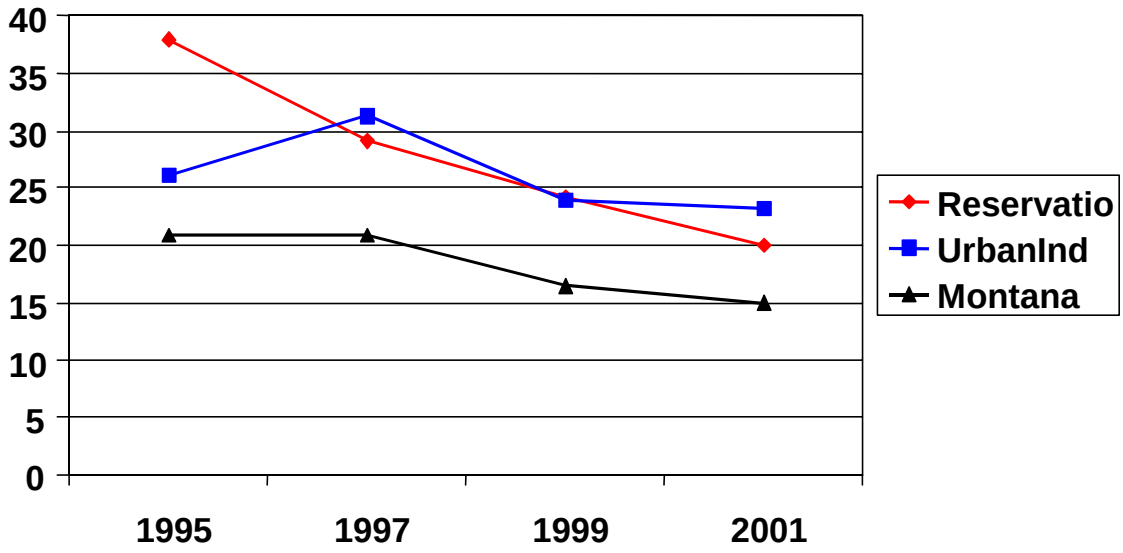
Figure 15 - Current Marijuana Use
American Indian Youth, 1991-2001
Montana Youth Risk Behavior Survey (YRBS)



Overall trends in lifetime inhalant use are down for all three groups. At the beginning of the trend period 1995, the highest level of lifetime inhalant use was among Montana reservation Indian students at almost 38 percent, followed by urban Indian students at about 26 percent and Montana non-Indian students at about 21 percent. Interestingly, by the end of the trend period, 2001, the highest level of lifetime inhalant use was by urban Indian students at about 23 percent, followed by reservation Indian students at 20 percent and Montana non-Indian students at 15 percent. The group with the highest average level of lifetime

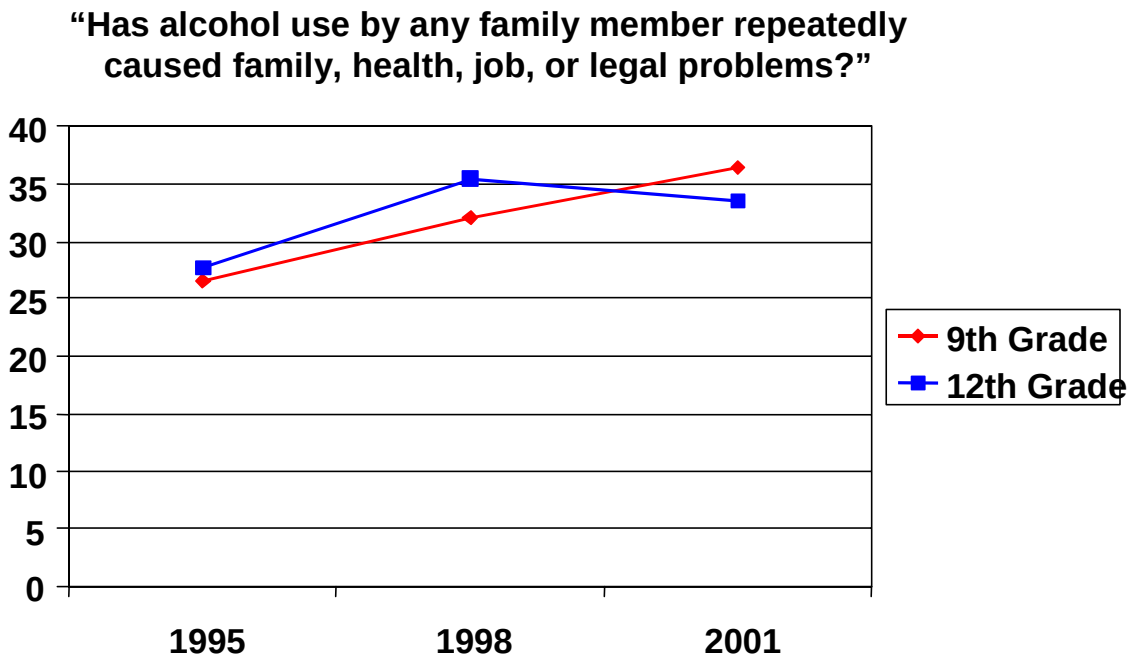
inhalant use was reservation Indian students at almost 28 percent, followed by urban Indian students at about 26 percent and Montana non-Indian students at about 18 percent. (See Figure 16.)

Figure 16 - Lifetime Inhalant Use
American Indian Youth, 1995-2001
Montana Youth Risk Behavior Survey (YRBS)



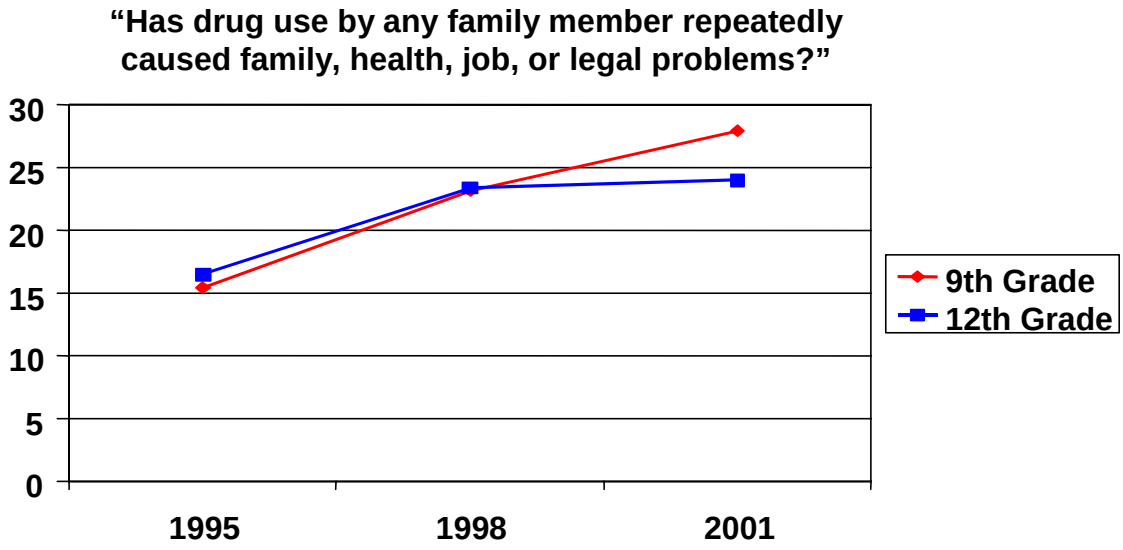
The **Minnesota Student Survey** has produced American Indian student trend data for years 1995, 1998, and 2001 for 9th and 12th graders. In 1995, 26.5 and 27.7 percent of American Indian 9th and 12th graders, respectively, reported that alcohol by a family member had repeatedly caused family, health, job, or legal problems. By 1998 the trend had risen to 32 and 35.5 percent for 9th and 12 graders, respectively. The trend continued to rise for American Indian 9th graders to 36.5 percent in 2001. The trend for American Indian 12th graders fell in 2001 to 33.5 percent. (See Figure 17.)

Figure 17 - Minnesota Student Survey



Similarly for the question, "Has drug use by any family member repeatedly caused family, health, job, or legal problems?", the overall trend from 1995 to 2001 was up for American Indian 9th and 12th graders. For American Indian 9th graders the trend rose from 15.5 percent to 28 percent. For American Indian 12th graders the trend rose from16.5 percent to 24 percent. (See Figure 18.)

Figure 18 - Minnesota Student Survey



The trend for cigarette smoking among American Indian students in Minnesota is down sharply for 9th and 12th graders. (See Figures 19 and 20.)

Figure 19 - Minnesota Student Survey
Percent of American Indian Students Who Smoked
1-5 Cigarettes or More Per Day During Last 30 Days

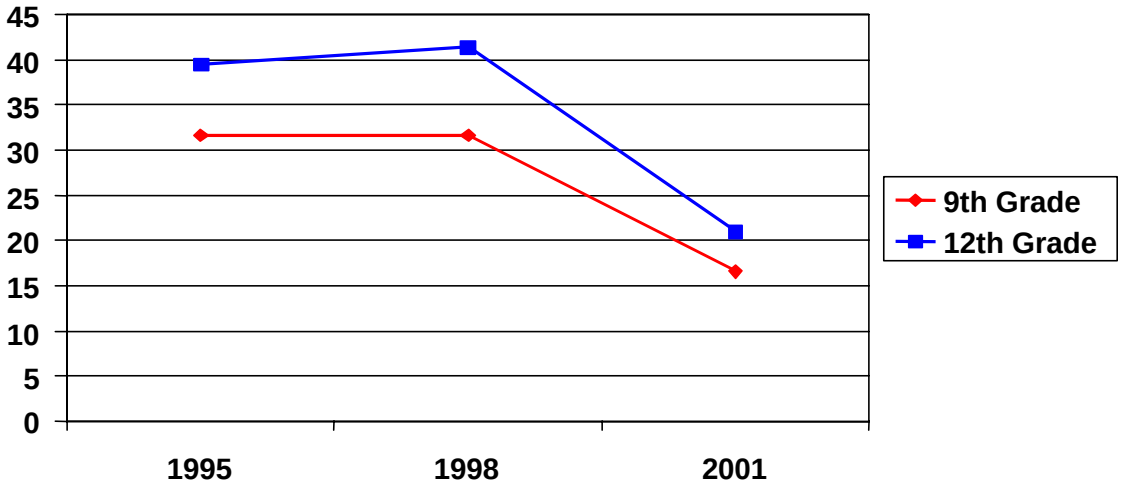
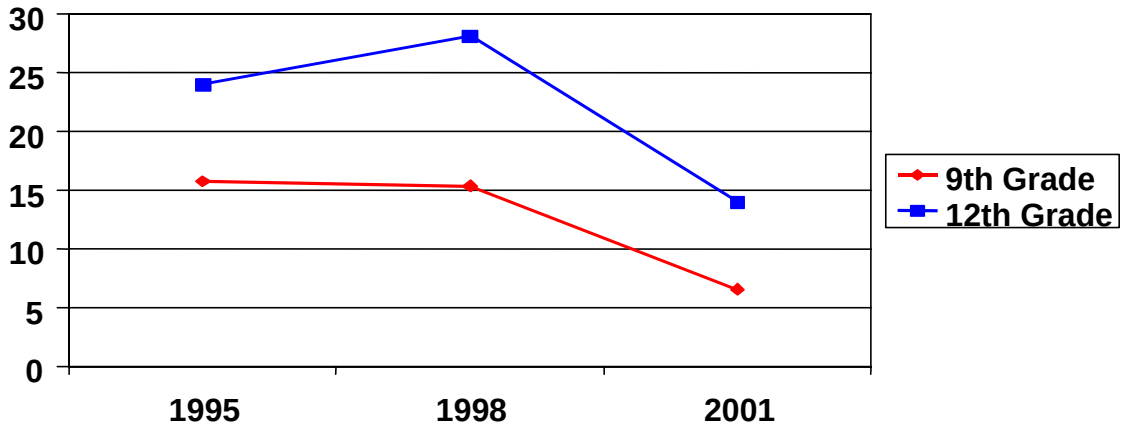


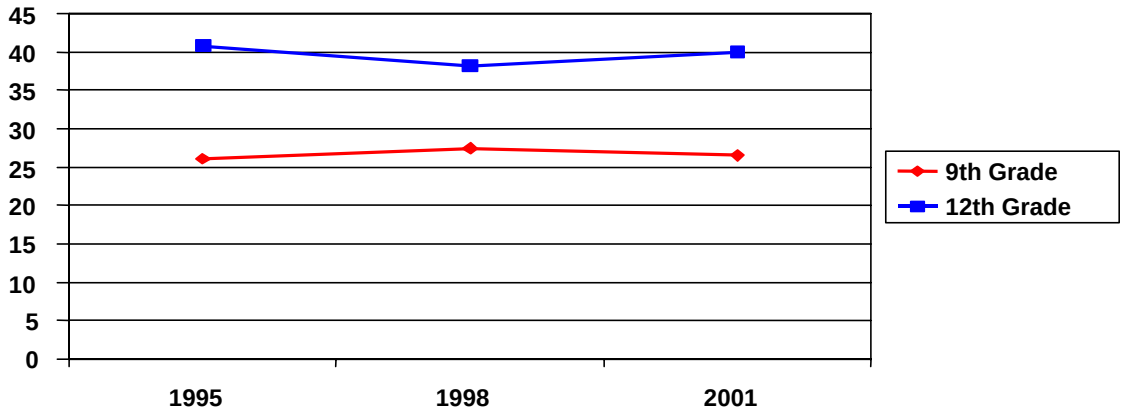
Figure 20 - Minnesota Student Survey
Percent of American Indian Students Who Smoked
a Half-pack or More Per Day During Last 30 Days



The proportion of American Indian students who smoked 1-5 cigarettes per day during the last thirty days is down from 31.6 percent in 1995 to 16.5 percent in 2001 for 9th graders and down from 39.5 percent to 21 percent for 12th graders. For American Indian students who smoked a half pack of cigarettes or more during the last thirty days, the trend for the same time period was down from 15.7 percent to 6.5 percent for 9th graders and down from 24 percent to 14 percent for 12th graders.

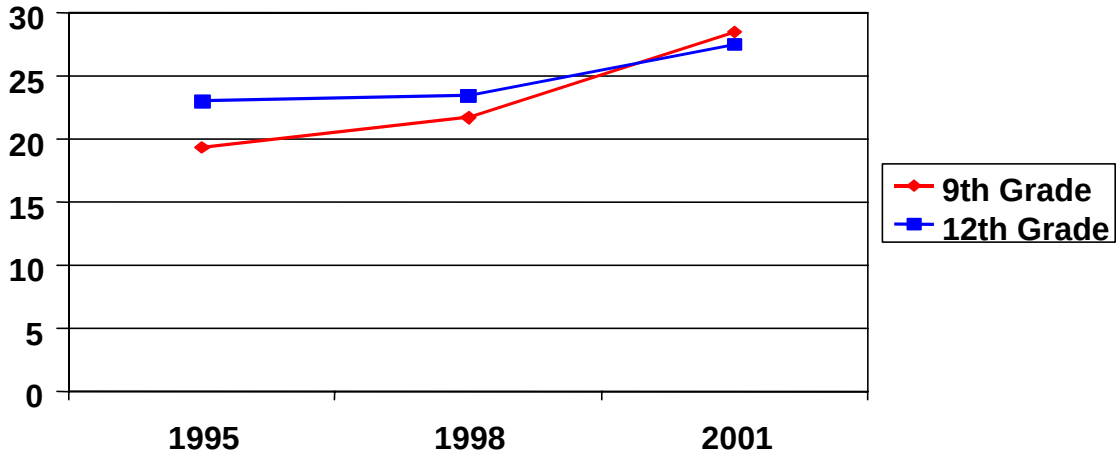
Unfortunately, the trends for alcohol and marijuana use are not as good as those for cigarette smoking. The proportion of American Indian students who drank alcohol on ten or more occasions in the last twelve months for both 9th and 12th graders had not changed very much between 1995 and 2001. On the average, between 1995 and 2001, over 26 percent of 9th graders and about 40 percent of 12th graders reported drinking alcohol on ten or more occasions over the past year. (See Figure 21)

Figure 21 - Minnesota Student Survey
Percent of American Indian Students Who Drank Alcohol
on 10 or More Occasions in the Last 12 Months



The overall trend in marijuana smoking was up for both 9th and 12th grade American Indian students. The percent of American Indian 9th graders who used marijuana on ten or more occasions in the last twelve months grew from 19.3 percent in 1995 to 28.5 percent in 2001. For American Indian 12th graders, the trend rose from 23 percent in 1995 to 27.5 percent in 2001. (See Figure 22.)

Figure 22 - Minnesota Student Survey
Percent of American Indian Students Who Used
Marijuana on 10 or More Occasions in Last 12 Months



LAW ENFORCEMENT DATA

Law enforcement data were gathered from five sites. These included Warm Springs Reservation, Salish-Kootenai Reservation, United Indian Health Services, Minneapolis, and NW New Mexico Fighting Back.

Warm Springs Reservation. For the period of interest, 1995 to 2000, law enforcement information was gathered for arrests of adults and juveniles driving under the influence (DUI), adults and juveniles in substance-abuse detoxification, adult and juvenile drug arrests, adult and juvenile liquor violations, and juveniles in possession of alcohol or drugs.

The overall trend in adult and juvenile DUI arrests has been down. Among adults, the number of arrests has gone down from 157 in 1995 to 99 in 2000. However, from 1995 to 1999 the number of arrests dropped considerably from 157 to 49, but rising in 2000 to 99 arrests. Although juvenile arrests for DUI have been five arrests or fewer between 1995 and 1999, there has been a steady decline since 1997. (See Figures 23 and 24.)

Figure 23 - Warm Springs Reservation
Driving Under the Influence Arrests, 1995-2000

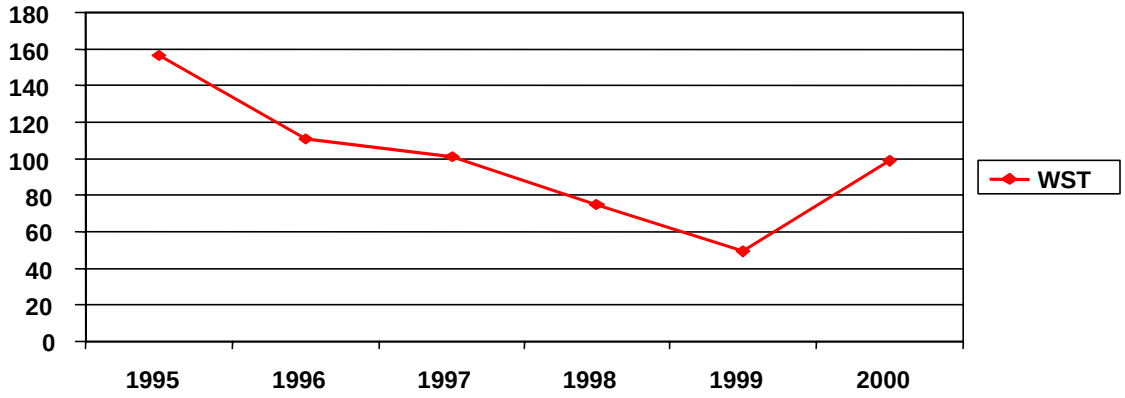
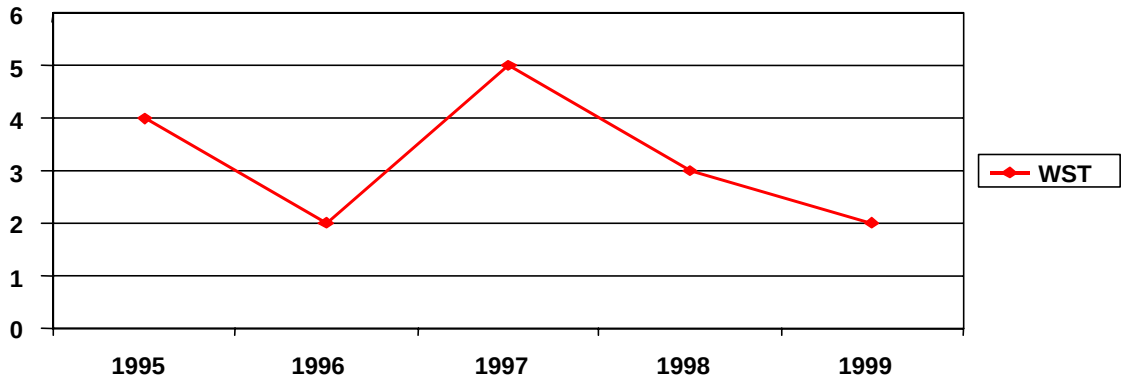


Figure 24 - Warm Springs Reservation
Juvenile Driving Under the Influence Arrests, 1995-1999



The number of adults and juveniles in substance-abuse detoxification declined between 1995 and 2000. Among adults we see a similar, if not quite so marked, trend for DUI arrests. Between 1995 and 1999, the number of adults in substance abuse detoxification fell from 1,295 to 789. However, the trend increased the following year when the number rose to 911. The number of juveniles in substance-abuse detoxification declined from 24 in 1995 to 5 in 2000, with only 3 in 1998. (See Figures 25 and 26.)

Figure 25 - Warm Springs Reservation
Adults in Substance-Abuse Detoxification, 1995-2000

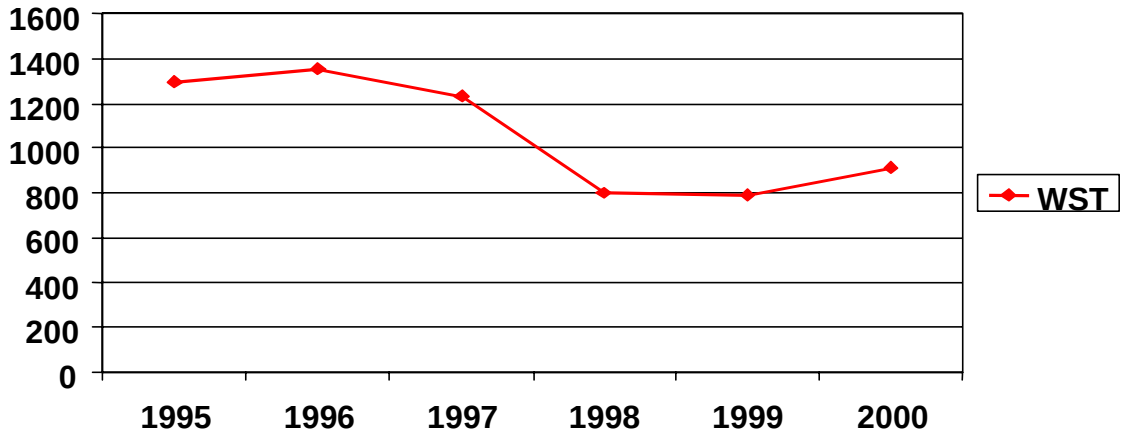
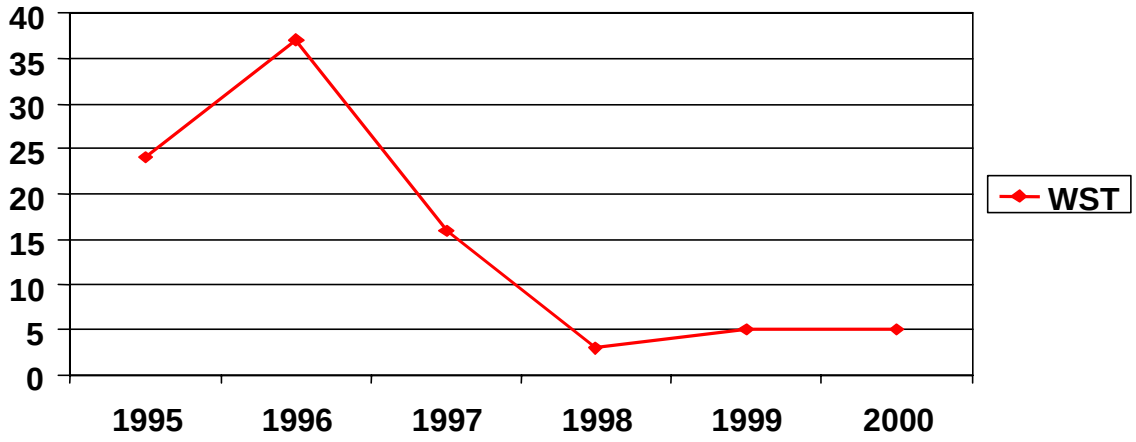


Figure 26 - Warm Springs Reservation
Juveniles in Substance-Abuse Detoxification, 1995-2000



The overall trend in adult drug arrests has been down—from 94 arrests in 1995 to 69 in 2000. However, since 1999 the trend has been up—rising from 39 to 69 arrests. The overall trend in juvenile drug arrests has been up—from 13 arrests in 1995 to 19 in 1999. (See Figures 27 and 28.)

Figure 27 - Warm Springs Reservation
Adult Drug Arrests, 1995-2000

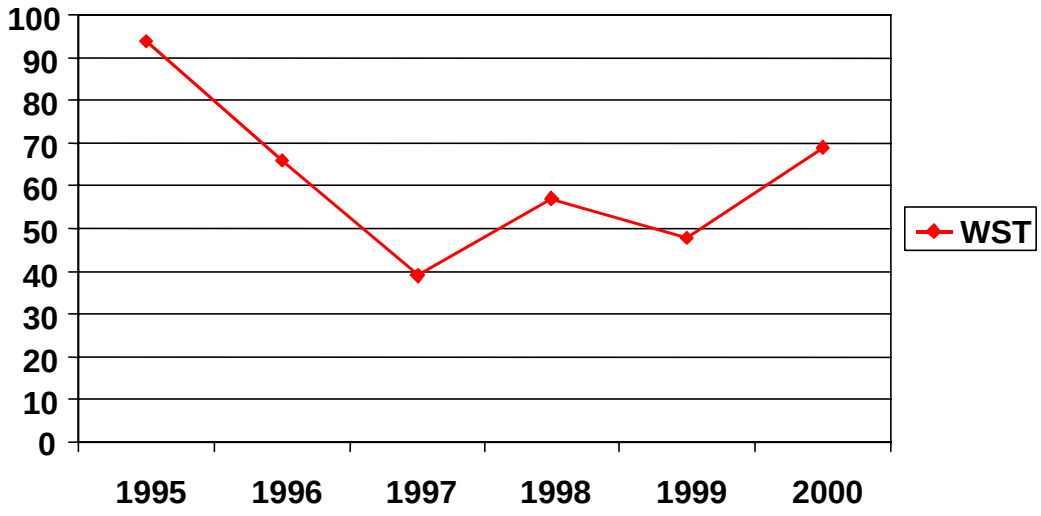
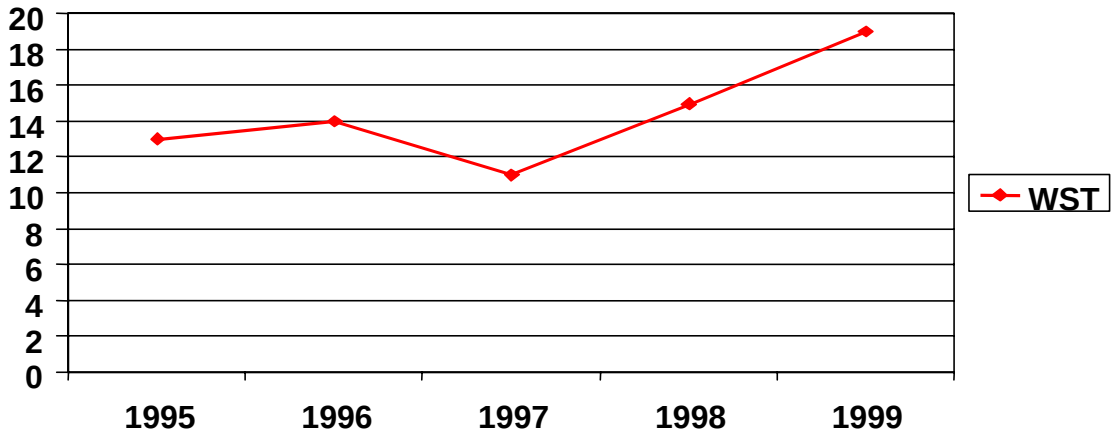


Figure 28 - Warm Springs Reservation
Juvenile Drug Arrests, 1995-1999



Overall, adult liquor violations declined from 1995 to 2000 at Warm Springs Reservation. From 1995 to 1998, the number of adult liquor violations dropped from 171 to 47. In 1999 the number rose to 115 violations, dropping again in 2000 to 77 liquor violations. Juvenile liquor violations numbered 5 or fewer between 1995 and 1999. (See Figures 29 and 30.)

Figure 29 - Warm Springs Reservation
Adult Liquor Violations, 1995-2000

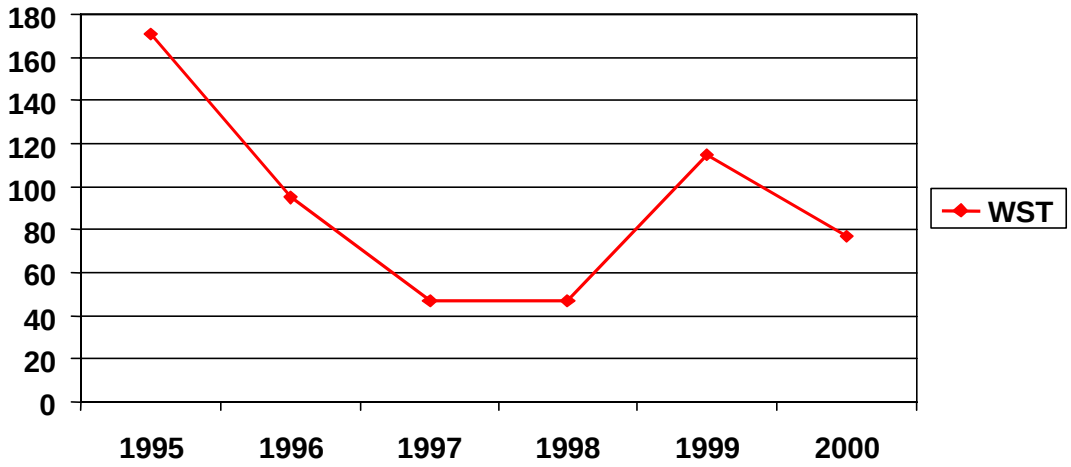
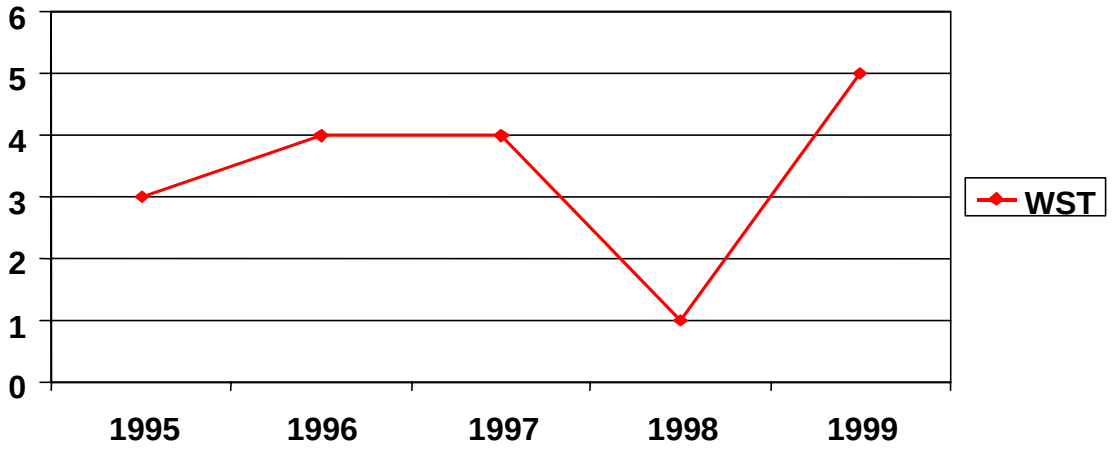
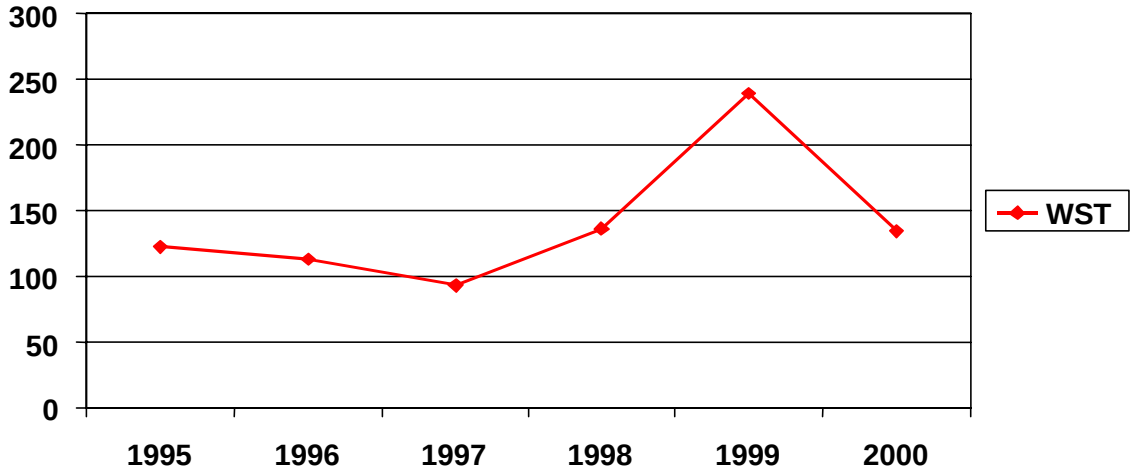


Figure 30 - Warm Springs Reservation
Juvenile Liquor Violations, 1995-1999



Between 1995 and 1997, the number of Warm Springs Tribes youth found in possession of alcohol or drugs fell from 122 to 93. The number rose the following two years to 136 and 239, respectively. The number dropped again in 2000 to 134 juveniles found in possession of alcohol or liquor. (See Figure 31.)

Figure 31 - Warm Springs Reservation
Juveniles in Possession of Alcohol or Drugs, 1995-2000



Salish-Kootenai Reservation. Law enforcement information gathered at the Salish-Kootenai Reservation for the period 1995 to 2001 included total adult and juvenile citations, adult drug- and alcohol-related citations, adult drug violations, adult liquor violations, the number of adult DUI arrests, and the number of juvenile public nuisance arrests.

The overall trend in Salish-Kootenai adult citations for all causes fell between 1995 and 2001 from 2,343 to 1,644 citations. From 1997 to 1999, the trend rose from 1,762 to 2,206 citations before falling to the 2001 level. Conversely, the trend in Salish-Kootenai juvenile citations increased dramatically from 1996 to 1998 from 169 to 682 citations. From 1998 to 2000, the trend continued to rise to 729 citations, before falling slightly in 2001 to 683 citations. (See Figures 32 and 33.)

Figure 32 - Salish-Kootenai Reservation
Total Adult Substance-Abuse-Related
Arrests, 1995-2001

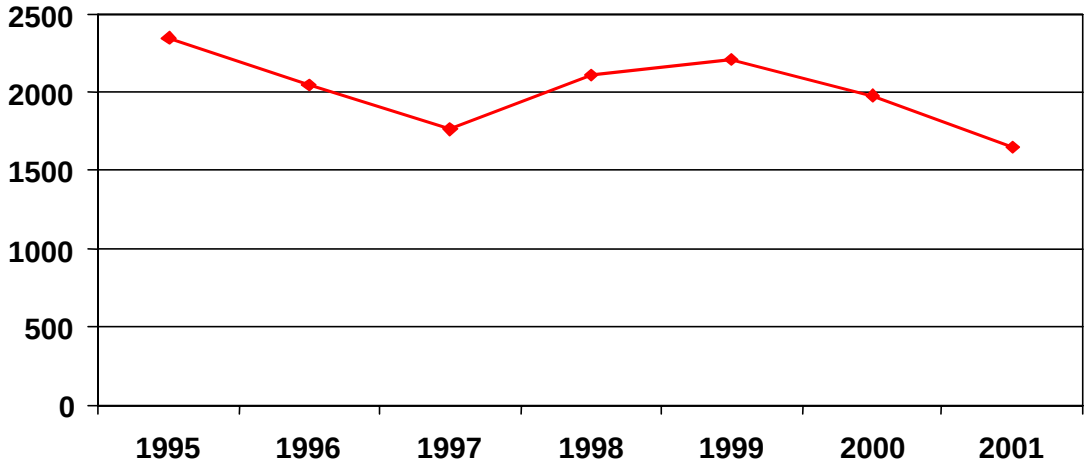
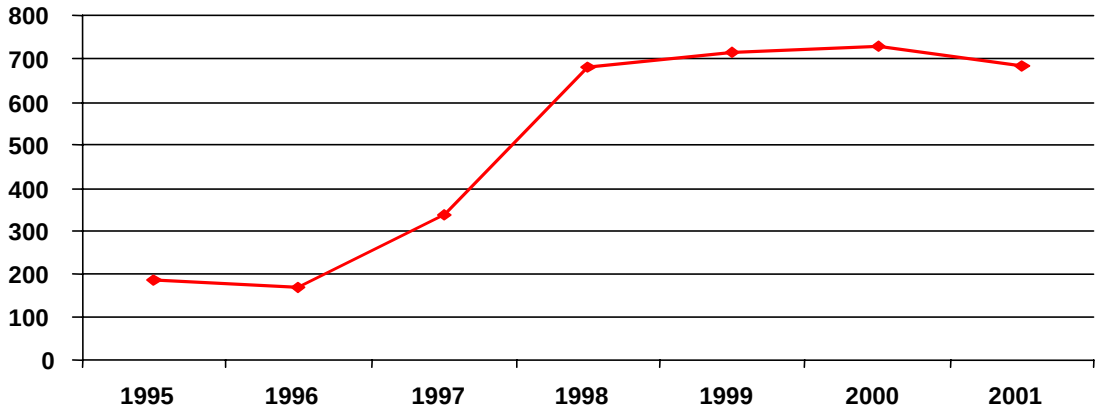
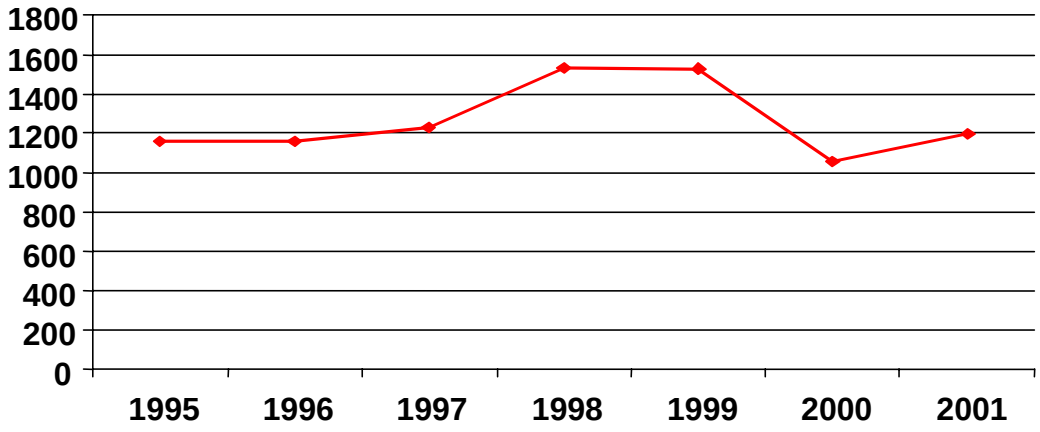


Figure 33 - Salish-Kootenai Reservation
Total Juvenile Arrests, 1995 to 2001



A large (and for some years, a very large) proportion of adult citations were drug and alcohol citations. In 1995 about half of all adult citations were drug or alcohol citations. In 2001 almost 73 percent of adult citations were drug or alcohol citations. The overall trend in adult drug and alcohol citations rose during the period 1995 to 1998 and in 1999. The trend fell in 2000 to a low of 1,055 citations for the period, rising again in 2001 to 1,194 citations. (See Figure 34.)

Figure 34 - Salish-Kootenai Reservation
Drug- and Alcohol-Related Arrests, 1995-2001



Drug violations on the Salish-Kootenai Reservation rose between 1995 and 2001 from 83 to 118. In between, in 1997 and 2000, the number of drug violations was highest at 135 and 125, respectively. Similarly, the trend in liquor violations also went up between 1995 and 2001 from 222 to 417. In 1998 and 1999, the number of liquor violations was highest for this period—432 and 453, respectively. (See Figures 35 and 36.)

Figure 35 - Salish-Kootenai Reservation
Total Drug Violations, 1995-2001

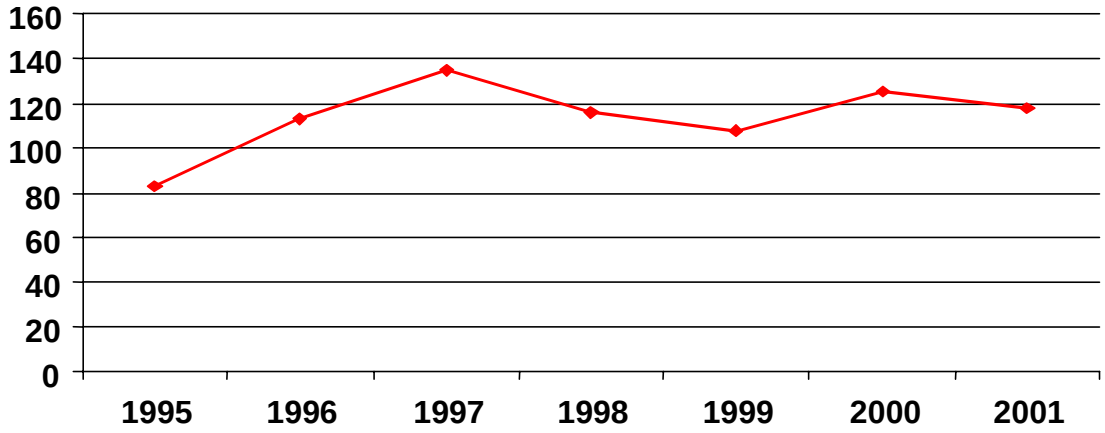
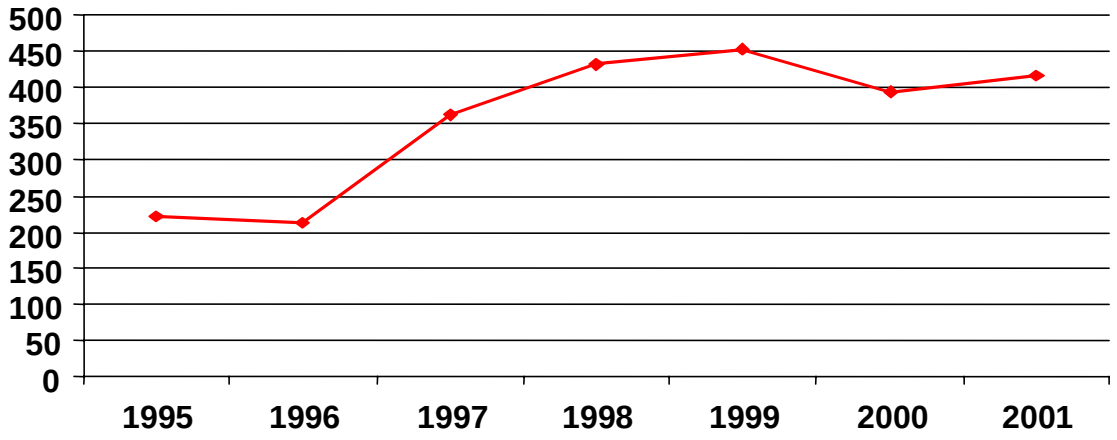
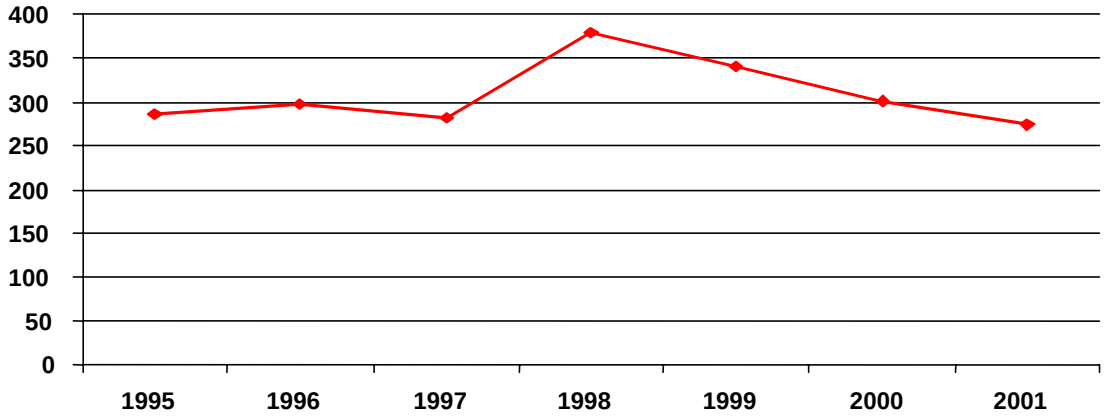


Figure 36 - Salish-Kootenai Reservation
Total Liquor Violations, 1995-2001



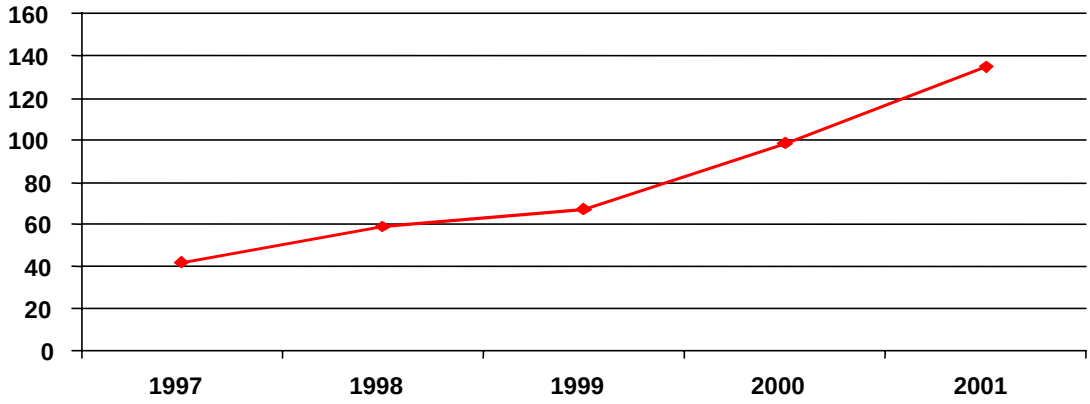
The overall trend in arrests for driving under the influence at the Salish-Kootenai Reservation did not change very much between 1995 and 2001. There were 287 DUI arrests at the beginning of this period and 274 DUI arrests at the end of the period. The trend rose to 379 DUI arrests in 1998 and has steadily declined since then. (See Figure 37.)

Figure 37 - Salish-Kootenai Reservation
Driving-Under-the-Influence Arrests, 1995-2001



Arrests for public nuisance—a category that most often included young people and alcohol or drugs—was established on the Salish-Kootenai Reservation in 1997. Since then the number of arrests has grown steadily each year from 47 arrests to 135 arrests in 2001. (See Figure 38.)

Figure 38 - Salish-Kootenai Reservation
Annual Public Nuisance Arrests, 1997-2001



United Indian Health Services, Inc. Law enforcement information gathered from the community served by the United Indian Health Services, Inc. for the period 1997 to 2002 included the following:

- information on the minority county jail population
- American Indian juvenile probation referrals
- juvenile alcohol and drug probation referrals
- juvenile alcohol and drug probation referrals by gender
- American Indian youth in custody at Juvenile Hall and at a regional facility
- American Indian new diversions and new intakes for alcohol and substance abuse treatment

From 1997 to 2002, most of the people in the Del Norte County, California, jail were white Americans—numbering between 70 and 80 people. However, the second most numerous group of people making up the jail population were American Indians—more than African-Americans and more than Latinos. The number of American Indians in the county jail from 1997 to 2002 has been consistent at about 14 people.

The overall trend in the number of American Indian juvenile probation referrals grew from 65 referrals in 1997 to 126 and 125 referrals in 2001 and 2002, respectively. Of these American Indian juvenile referrals for probation, the number of alcohol and drug probation referrals also grew steadily over the period 1997 to 2002, especially since 2002. For all but two years there were 20 or more American Indian alcohol or drug probation referrals. (See Figures 39 and 40.)

Figure 39 - American Indian Juvenile Probation Referrals,1997-2002
United Indian Health Services, Inc., Del Norte County, CA

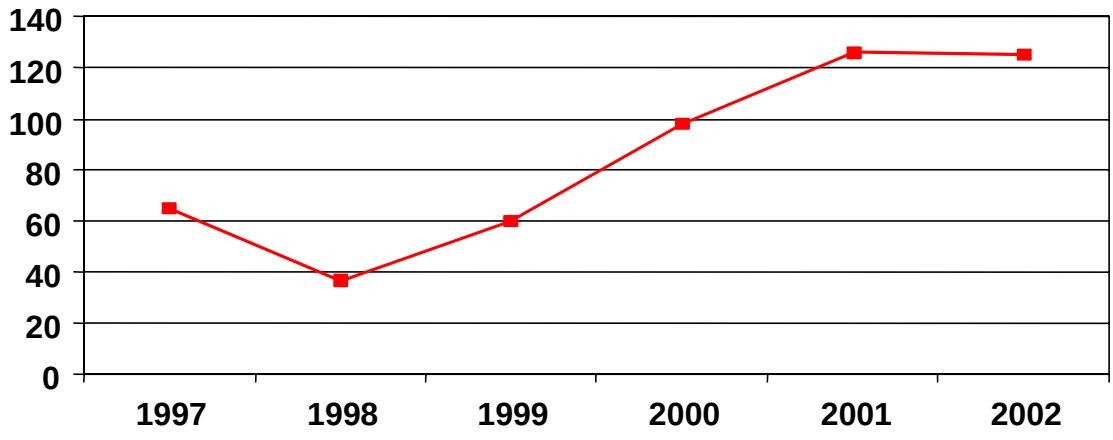
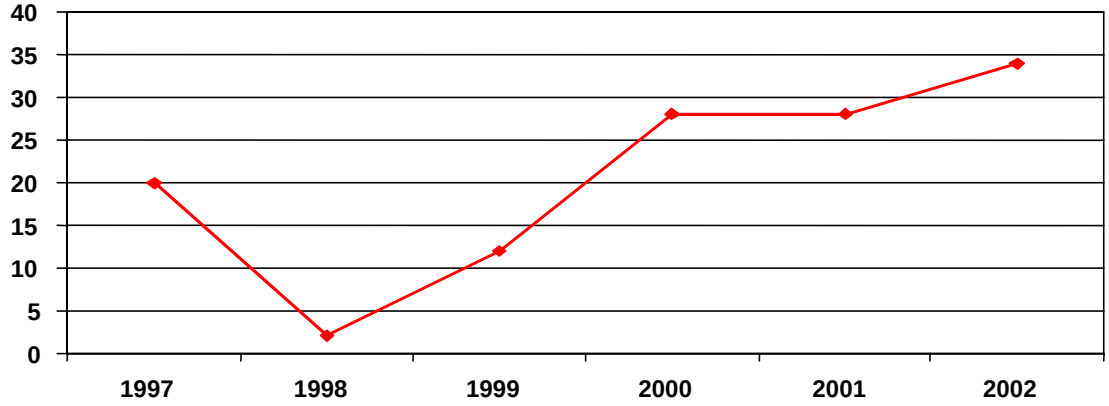
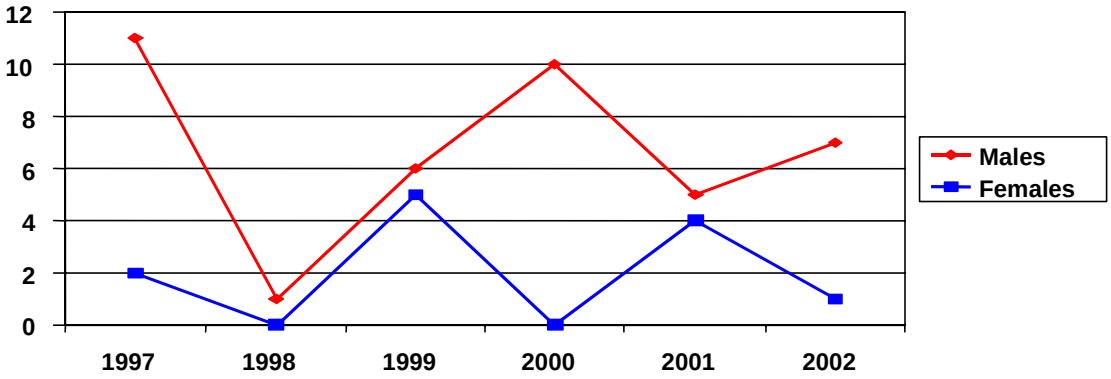


Figure 40 - American Indian Juvenile Alcohol and Drug Probation Referrals, 1997-2002
United Indian Health Services, Inc., Del Norte County, CA



While the numbers are small—fewer than twenty for each year of interest—the trend among American Indian boys and girls in the numbers of alcohol-related probation referrals was one of annual change. (See Figure 41.)

Figure 41 - American Indian Juvenile Alcohol-Related Probation Referrals, 1997-2002
United Indian Health Services, Inc,. Del Norte County, CA



However, the trend for both American Indian boys and girls for drug-related probation referrals was clearly up, especially for boys. From 1999 to 2002 the number of referrals for drug-related probation for Indian boys grew from one

to fifteen; for girls the number of referrals for the same period grew from zero to nine. (See Figure 42.)

Figure 42 - American Indian Juvenile Drug-Related Probation Referrals, 1997-2002
United Indian Health Services, Inc., Del Norte County, CA

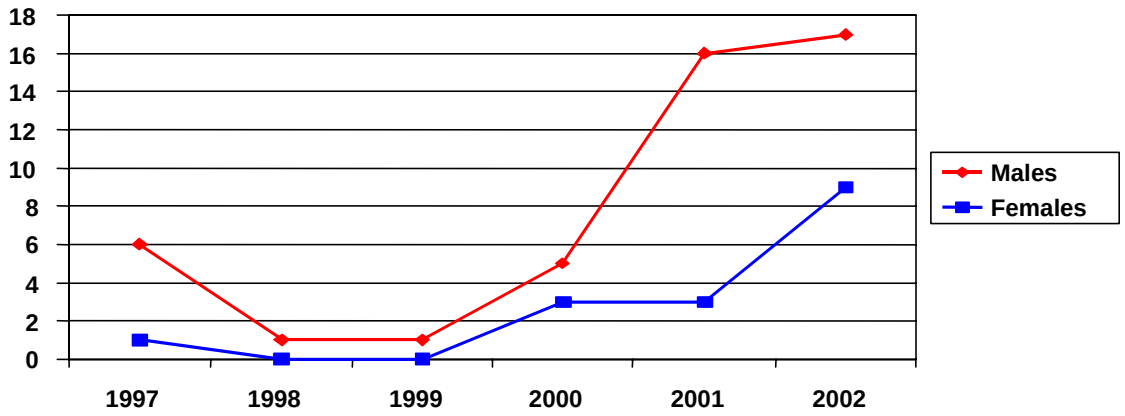


Figure 43 shows the trend in the numbers of American Indian youth in custody at Juvenile Hall and at a nearby regional facility from 1997 to 2002. American Indian youth held in custody at the regional facility since 1999 numbered fifteen or fewer. However, the number of American Indian youth held in custody at the Humboldt County, California, Juvenile Hall ranged from a high of 83 in 2001 to a low of 62 in 1999. The overall trend rose from 1997 to 2001, falling from 83 to 54 in 2002.

Figure 43 - American Indian Youth in Custody,
Juvenile Hall and Regional Facility, 1997-2002
United Indian Health Services, Inc., Humboldt County, CA

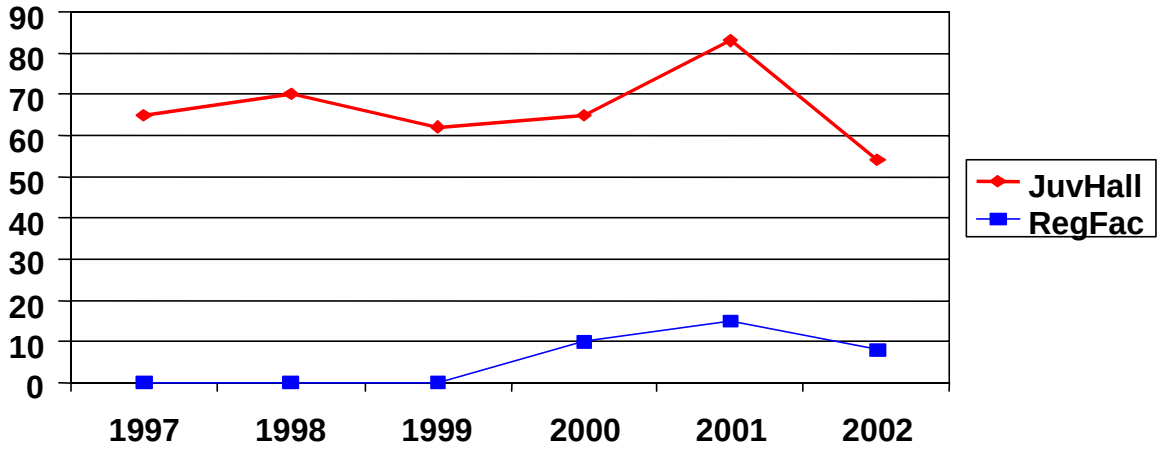
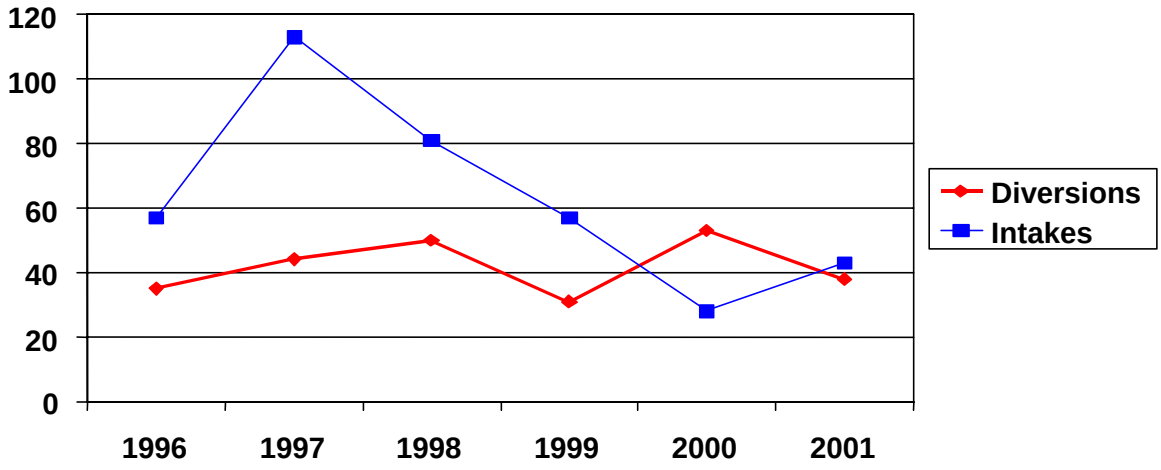


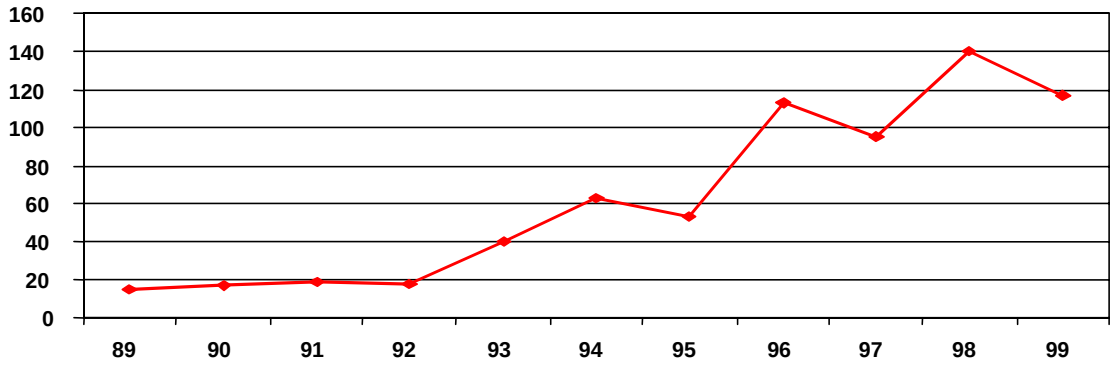
Figure 44 shows the number of American Indian youth diversions and new intakes for Alcohol/Substance Abuse (ASA) treatment from 1996 to 2001. The overall trend for youth diversions was down while the trend in new intakes has stayed about the same.

Figure 44 - American Indian Youth, New Diversions and New Intakes for ASA Treatment, 1996-2001
United Indian Health Services, Inc.



Minneapolis American Indian Center. American Indian and Alaska Native adult and juvenile law enforcement information was collected from the state of Minnesota for the state and for Hennepin County. Law enforcement information included narcotics offenses, driving under the influence, and liquor law violations. With only a few instances where the number of arrests or violations went down, most trends were up. For example, for the entire state, American Indian juvenile arrests for narcotics offenses rose from 15 arrests in 1989 to 140 in 1998, falling to 117 in 1999. (See Figure 45.)

Figure 45 - State of Minnesota, American Indian Juvenile Apprehensions for Narcotics Offenses, 1989-1999



American Indian DUI arrests in the state of Minnesota grew from 10 in 1989 to 32 in 1999. (See Figure 46.) For juvenile arrests for liquor violations the number of American Indian arrests grew from 118 in 1989 to 536 in 1998, falling to 472 in 1999. (See Figure 47.)

Figure 46 - State of Minnesota, American Indian Juvenile Apprehensions for Driving Under the Influence, 1989-1999

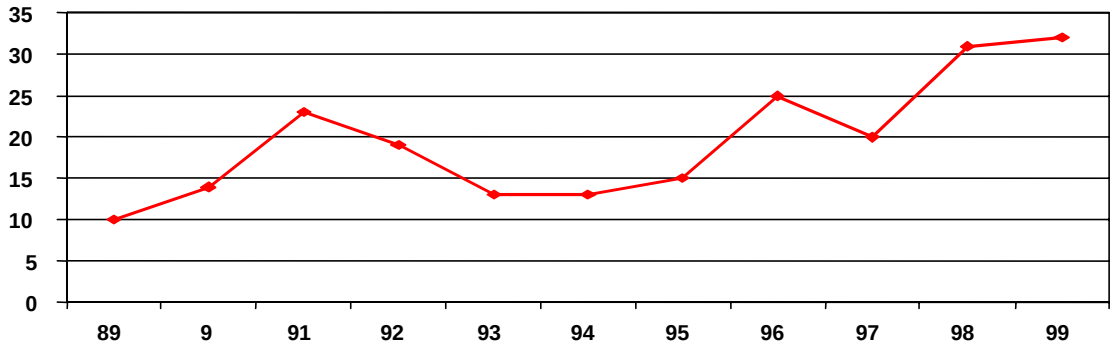
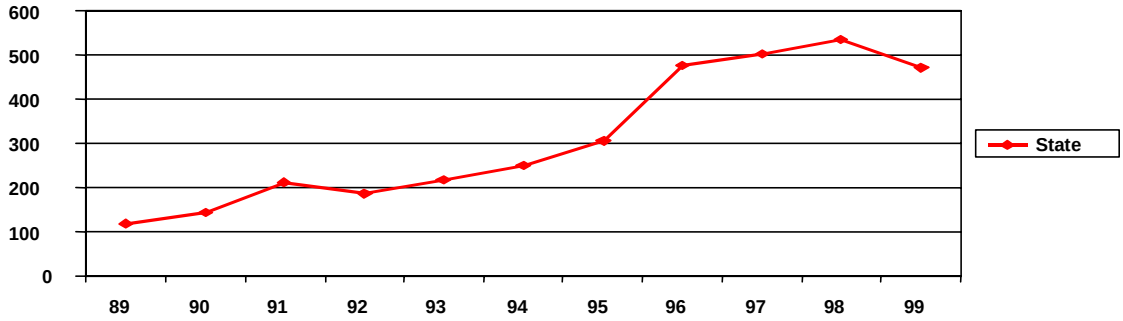


Figure 47 - State of Minnesota, American Indian Juvenile Apprehensions for Liquor Law Violations, 1989-1999



In Hennepin County, Minnesota, for the period 1989 to 1999, American Indian juvenile arrests for narcotics offenses grew from 7 in 1989 to 51 in 1999. (See Figure 48.) DUI arrests among American Indian youth never grew over five in any one year and averaged two arrests per year during the period of interest. American Indian juvenile arrests for liquor violations, however, grew from eight in 1990, 1991, and 1992 to 123 in 1998, falling to 116 in 1999. (See Figures 49 and 50.)

Figure 48 - Hennepin County, Minnesota, American Indian Juvenile Apprehensions for Narcotics Offenses, 1989-1999

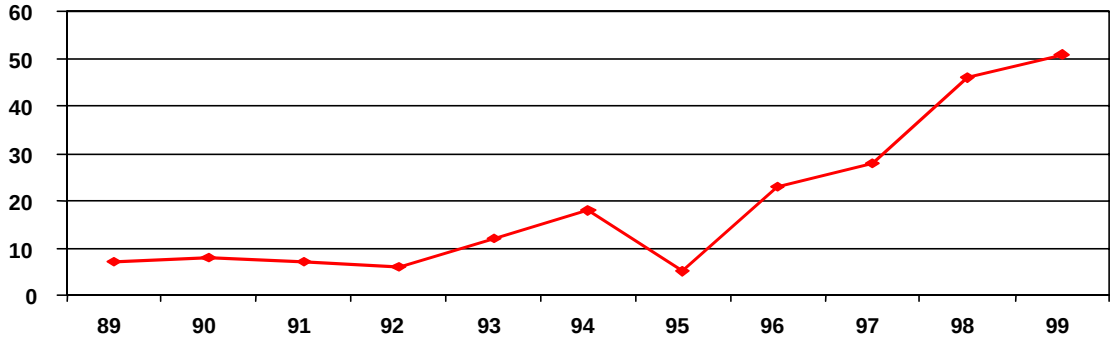


Figure 49 - Hennepin County, Minnesota, American Indian Juvenile Arrests for Driving Under the Influence, 1989-1999

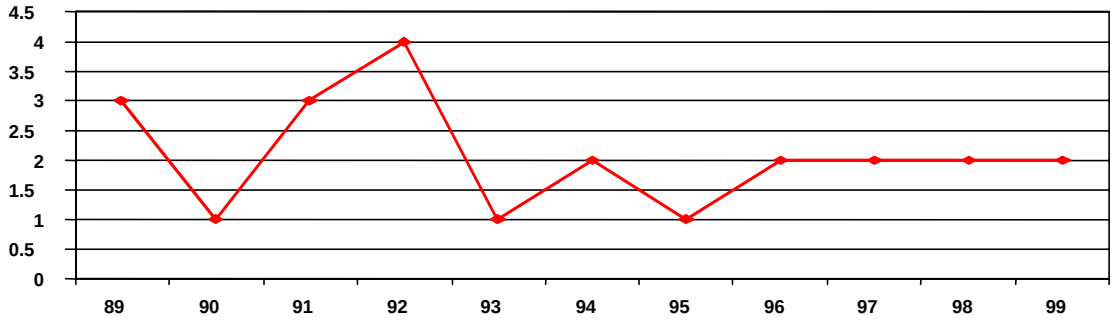
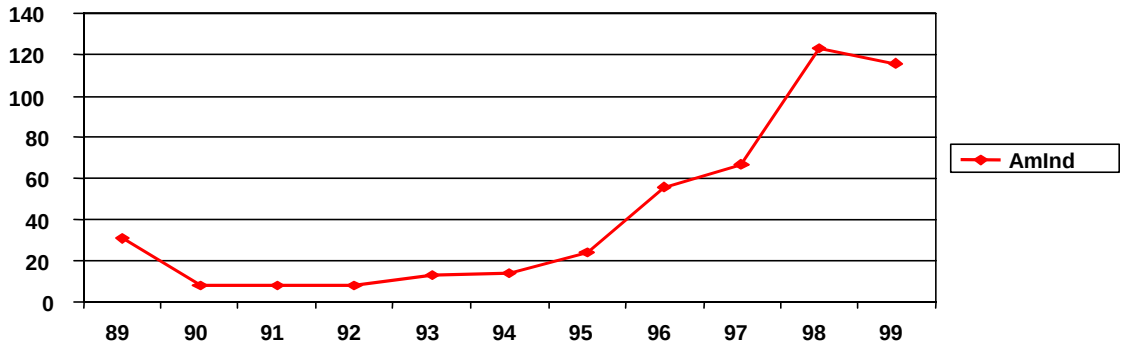


Figure 50 - Hennepin County, Minnesota, American Indian Juvenile Liquor Law Violations, 1989-1999



American Indian adult arrests in the State of Minnesota for narcotics offenses grew from 122 in 1989 to 363 in 1999. (See Figure 51.) American Indian adult arrests for the period for driving under the influence grew from 800 to a high of 1,272 in 1997, falling thereafter to 1,256 in 1998 and 1,230 in 1999. (See Figure 52.) American Indian adult arrests for liquor law violations rose from 288 in 1989 to a high, for the period, of 1,147, dropping to 1,031 arrests in 1999. (See Figure 53.)

Figure 51 - State of Minnesota, American Indian Adult Arrests for Narcotics Offenses, 1989-1999

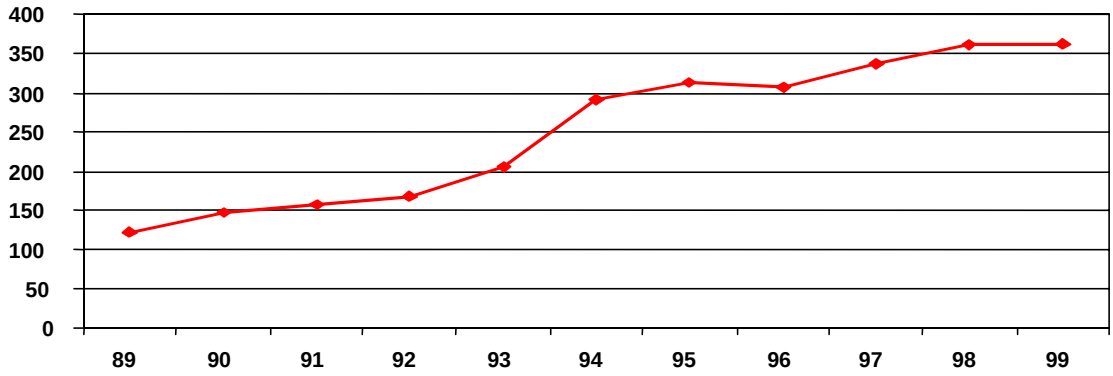


Figure 52 - State of Minnesota, American Indian Adult Arrests for Driving Under the Influence, 1989-1999

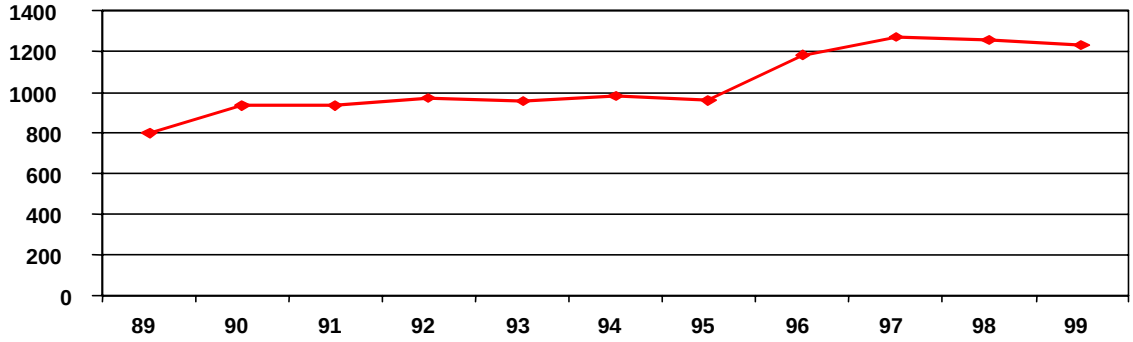
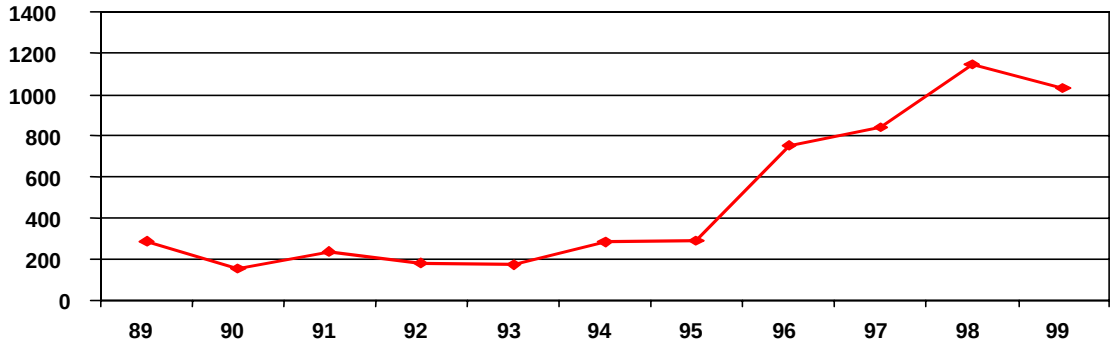


Figure 53 - State of Minnesota, American Indian Adult Arrests for Liquor Law Violations, 1989-1999



Adult American Indian arrests in Hennepin County for narcotics offenses grew from 44 in 1989 to a high, for the period, of 136 in 1998, falling to 127 arrests in 1999. (See Figure 54.) American Indian adult arrests for DUI fell from 272 arrests in 1989 to a low, for the period, of 159 in 1995. From 1995 to 1999, the number of American Indian adult DUI arrests rose to 247 in 1996 and then fell to 242 arrests in 1997 and 220 arrests in 1998, before rising in 1999 to 224 arrests. (See Figure 55.) From 1996 to 1999, the number of American Indian adult arrests for liquor law violations rose from 364 arrests to 775 arrests in 1998, falling to 671 arrests in 1999. (See Figure 56.)

Figure 54 - Hennepin County, Minnesota, American Indian Adult Arrests for Narcotics Offenses, 1989-1999

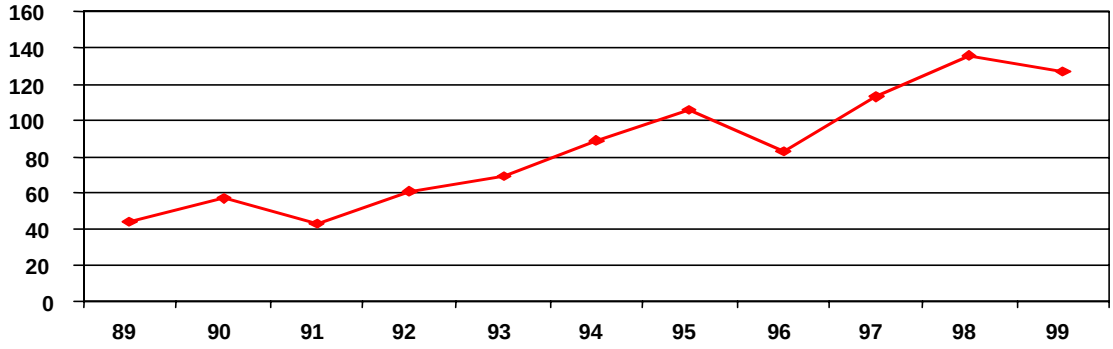


Figure 55 - Hennepin County, Minnesota, American Indian Adult Arrests for Driving Under the Influence, 1989-1999

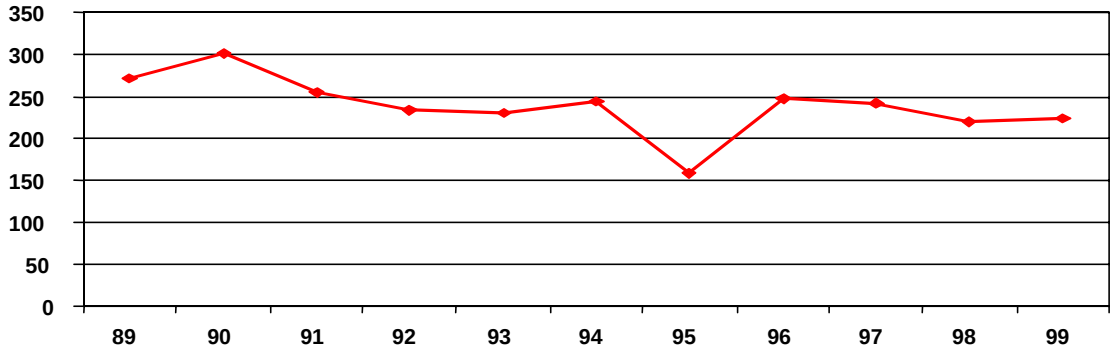
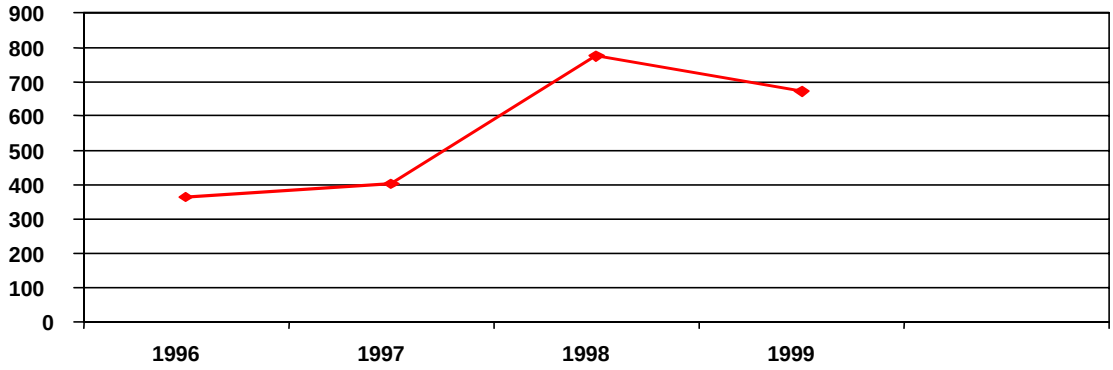


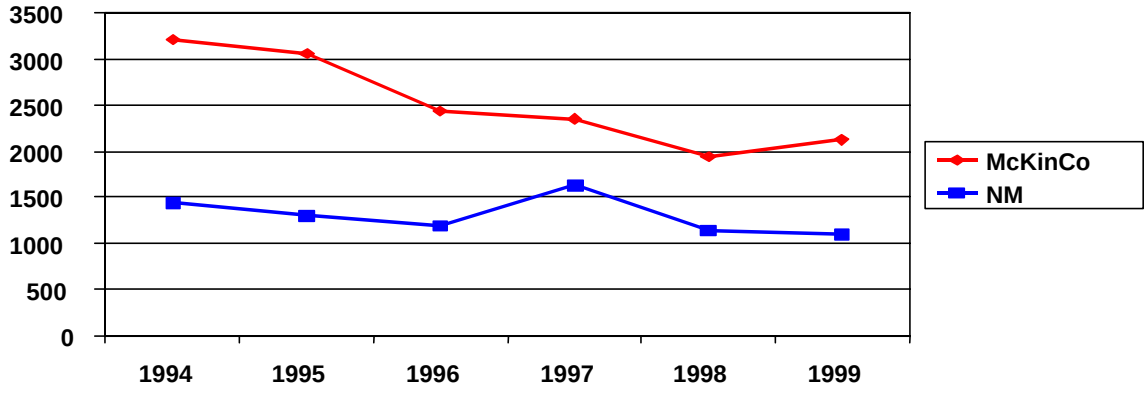
Figure 56 - Hennepin County, Minnesota, American Indian Adult Arrests for Liquor Law Violations, 1989-1999



NW New Mexico Fighting Back, Gallup, New Mexico. Law enforcement data gathered included arrests per 100,000 for Driving While Intoxicated (DWI), alcohol arrests per 100,000 population, and drug arrests per 100,000 population. Information was gathered from reports produced by the state of New Mexico, McKinley County, and Gallup, New Mexico. The available information is not specific to American Indians and Alaska Natives, although the population of McKinley County and Gallup, New Mexico, is predominately American Indian.

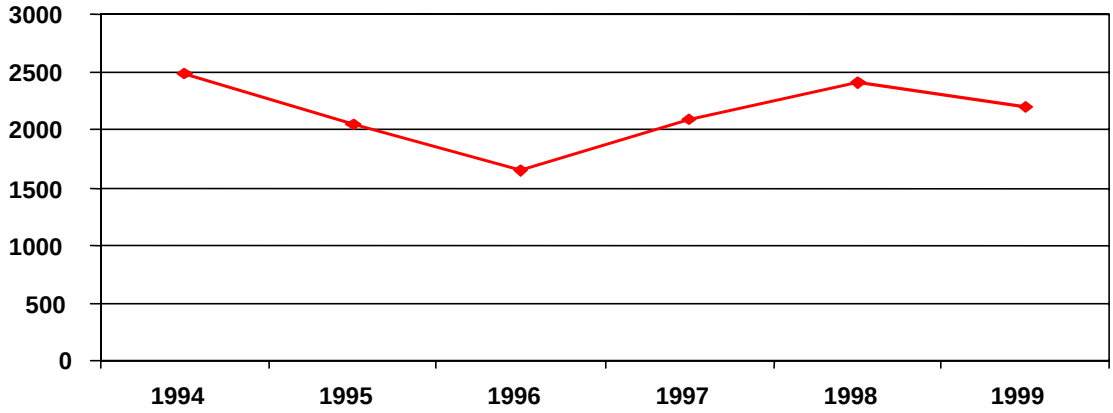
In McKinley County, New Mexico, the county in which the city of Gallup is located, the arrest rate per 100,000 population has declined from 1994 through 1999. In 1994 there were 3,210 arrests per 100,000 population. In 1999 there were 2,128 arrests per 100,000 population. Arrests per 100,000 for DWI went over 3,000 in 1994 and 1995. The overall trend has been down with spikes in the mid-1990s. From 1998 to 1999, the rate rose from 1,939 to 2,128. The arrest rate per 100,000 population for DWI in the state of New Mexico has also declined during the period 1994 to 1999. Despite a spike in 1997, the trend shows a steady decline to 1,092 arrests per 100,000 population in 1999. (See Figure 57.)

Figure 57 - NW New Mexico Fighting Back
DWI Arrest Rate, McKinley County and New Mexico
(Arrests/100,000 Population)



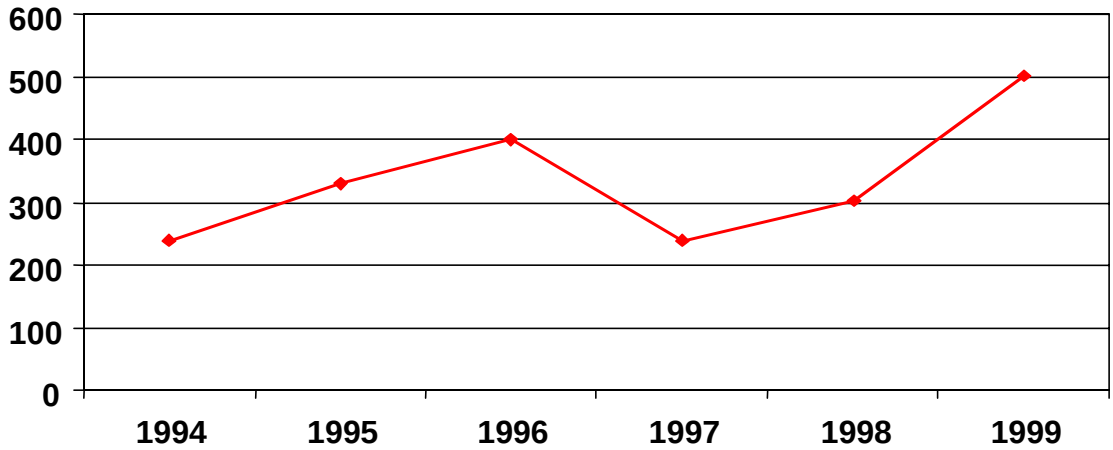
The trend in the number of alcohol-related arrests per 100,000 population in Gallup, New Mexico, shows a good decline from 1994 to 1996, falling from 2,490 to 1,650 arrests per 100,000. Since 1996, however, the number of alcohol-related arrests per 100,000 population rose to 2,090 in 1997 and 2,411 in 1998 per 100,000 population, falling to 2,206 arrests per 100,000 population in 1999. (See Figure 58.)

Figure 58 - NW New Mexico Fighting Back
Alcohol-Defined Arrest Rate, Gallup, NM
(Arrests/100,000 Population)



The overall trend in drug-related arrests in Gallup, New Mexico, from 1994 to 1999 was up. From 1994 to 1996, the number of drug-related arrests per 100,000 grew from 240 to 400. Although the number of drug-related arrests per 100,000 fell from 1996 to 1997, by 1999 there were 502 drug-related arrests per 100,000 population. (See Figure 59.)

Figure 59 - NW New Mexico Fighting Back
Drug-Defined Arrest Rate, Gallup, NM
(Arrests/100,000 Population)



SCHOOL DATA

School data were collected from four sites—Warm Springs, Salish-Kootenai, Minneapolis American Indian Center, and United Indian Health Services. Our purpose in looking at school data included the following two reasons:

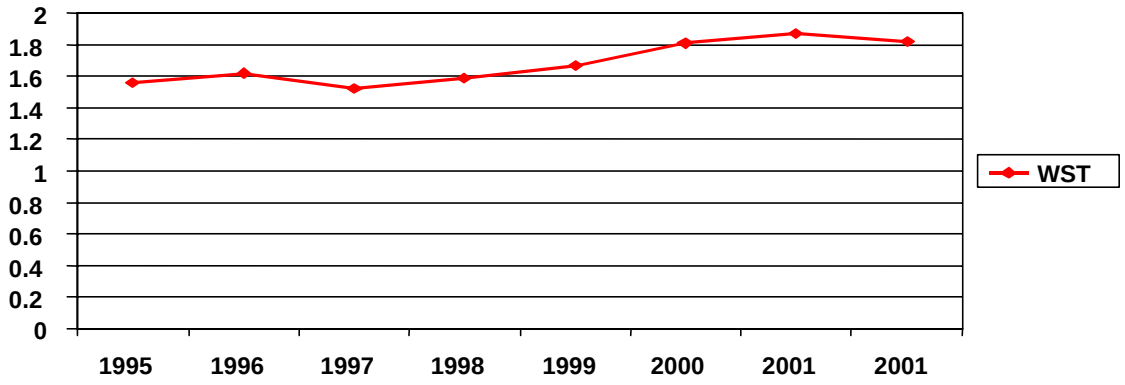
First, many of the activities developed by the Healthy Nations grantees were focused on young people. In fact, several of the grantees conducted significant portions of their overall programs with schools. Second, it was thought that one way to ascertain whether or not Healthy Nations activities had a positive impact on young people was to see if there were positive changes over time in things like grade-point averages, dropout rates, and graduation rates.

Warm Springs Reservation. Warm Springs Reservation school data were collected for the period 1995 through 2002 for grade-point averages, annual absenteeism rates, suspensions, and dropout rates. In addition, data were also collected for third grade proficiency levels for the Oregon Statewide Assessment of Reading and Math performance for the period 1996-2001.

Grade-point averages for students in grades 7 through 12 went up from 1.62 to1.82 (4.00 scale) from 1996 to 2001. The trend line, as shown in Figure 60, shows a modest but steady increase over this eight-year period. However, during the 2000-2001 academic year, grade-point averages for Indian students in middle schools and high schools decreased to 1.82 from the previous year's 1.91. As noted in their school district report, it is hoped that the recent decline

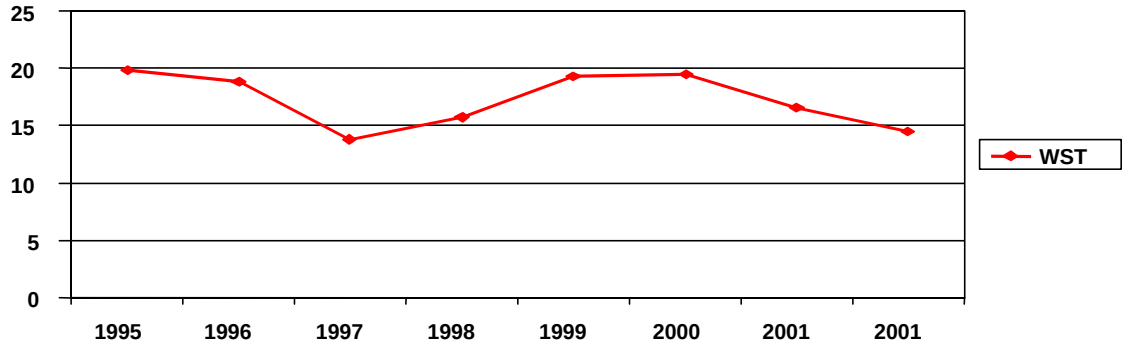
was not the beginning of a downward trend in Indian students' academic performance.

Figure 60 - Warm Springs Reservation
Annual High- and Middle-School Grade Point Averages,1995-2002



Data on annual absenteeism rates for Indian students at the Warm Springs Reservation indicate that the number of Indian students who were absent from school did not increase during the 2001-02 school year. Moreover, the overall absenteeism rate, measured by the percent of days absent, has decreased for students in grades 9-12. Unfortunately, this is not true for all grades, for which there has been a nominal increase in absenteeism. Nevertheless, for grades 9-12 the percent of days absent saw high rates in 1995-96 (18.9), 1998-99 (19.3) and 1999-00 (19.5). Since the 1999-00 school year, the rate has gone down to 16.6 in 2000-01 and to 14.5 in 2001-02. (See Figure 61.)

Figure 61 - Warm Springs Reservation
Annual High School Absenteeism Rates, 1995-2002



Suspension of Indian students increased sharply between 2001 and 2002 for both middle school and high school students. Since the 1995-96 school year, suspensions have ranged from between 123 middle school and high school students in the 1999-00 school year to 480 students in the 1995-96 school year. And, from 968 days suspended in the 1999-00 school year to 2,268 days suspended in the 2001-02 school year, respectively.

The number of suspensions for middle school and high school students combined increased to a high of 480 in the 2001-02 school year from the previous year's 305. The number of middle school students suspended increased from 204 (2000-01) to 338 in 2001-02. Most significantly, the number of days suspended for Indian middle school students jumped from 543 to 1691, an increase of almost 44 percent! In contrast, the increase for the high school Indian students was only 19 percent.

The total number of days suspended for grades 7-12 grew from 1,422 to 2,268—a very large increase of 37 percent between school years 2000-01 and 2001-02. Seventy-five percent of these 2,268 suspended days and seventy

percent of the 480 total suspensions were charged to middle school students. Further, of the 374 Indian students suspended during the year, 295 (79 percent) were middle school students. In terms of trends, since the mid-1990s, Indian high school student suspensions were declining until the 2001-02 school year. However, for middle school Indian students, suspensions rose sharply. While the frequency of suspension had increased, the severity remained about the same as the previous year (2000-01) as measured by the ratio of the number of days suspended to the number of students suspended.

Obviously, the school district and the education program at Warm Springs Reservation have been trying to answer a number of questions that might explain the extraordinary rise in the number of days suspended for the middle school students. There have been no changes in disciplinary procedures or policy, nor can school officials point to any specific event that has taken place in the schools or the community that might account for the rise in suspension days. (See Figures 62, 63, and 64.)

Figure 62 - Warm Springs Reservation
Suspensions of Middle School Students, 1996-2002

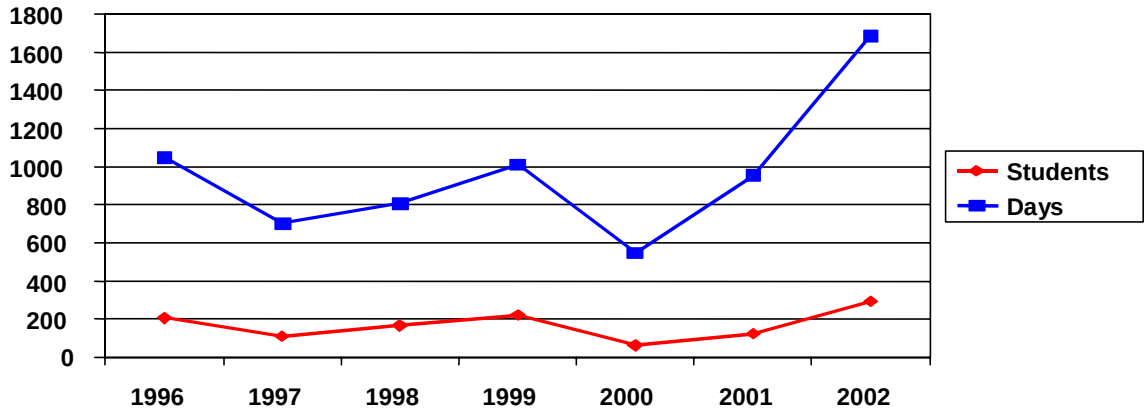


Figure 63 - Warm Springs Reservation
Suspensions of High School Students, 1996-2002

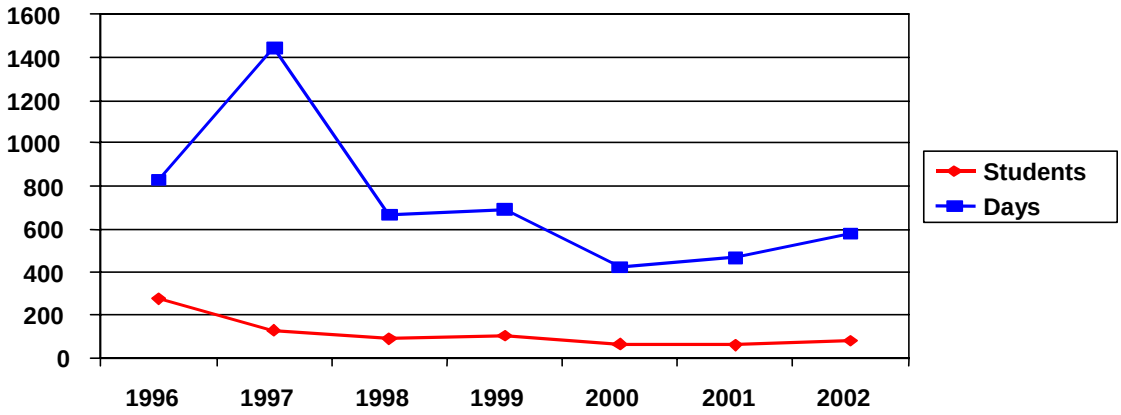
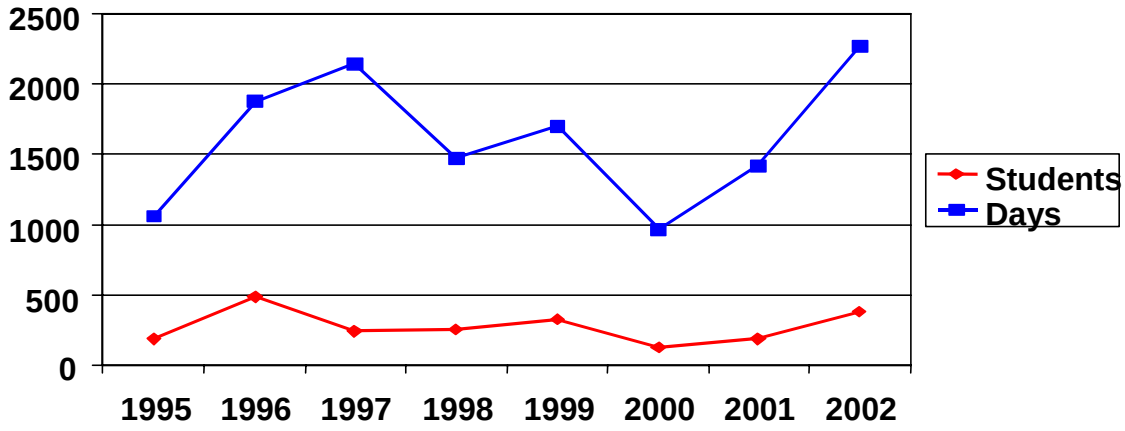


Figure 64 - Warm Springs Reservation
Suspensions of Middle- and High-School
Students, 1996-2002



The overall dropout rate has been steadily falling since the 1998-99 school year, when it was as high as 32 percent. However, between 1995-96 and 1998-99, there was a steady increase in the dropout rate—from 26 percent to 32 percent. For the school year 2001-02, the dropout rate for Indian students in grades 7 through 12 was 14 percent. This has been a great success for the school district. (See Figure 65.)

Figure 65 - Warm Springs Reservation
Student Dropout Rates, Grades 7-12, 1995-2002

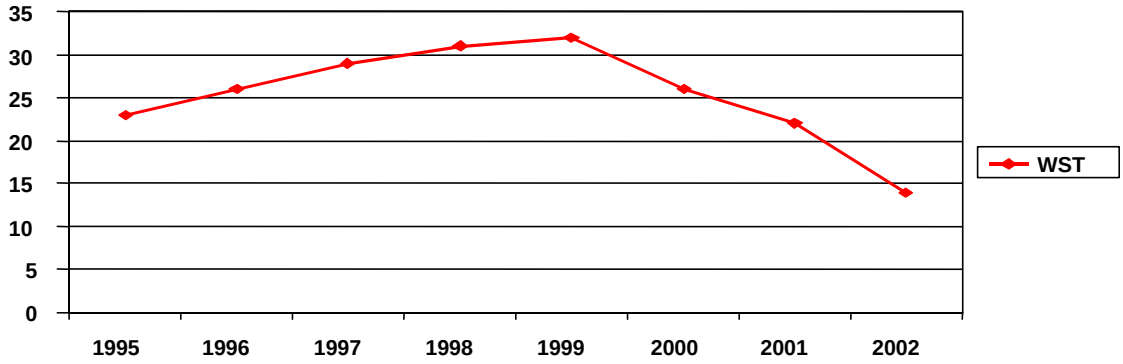


Figure 66 - Warm Springs Reservation
Third Graders Meeting or Exceeding Proficiency Level
Oregon Statewide Assessment of Reading/Math Performance, 1996-2001

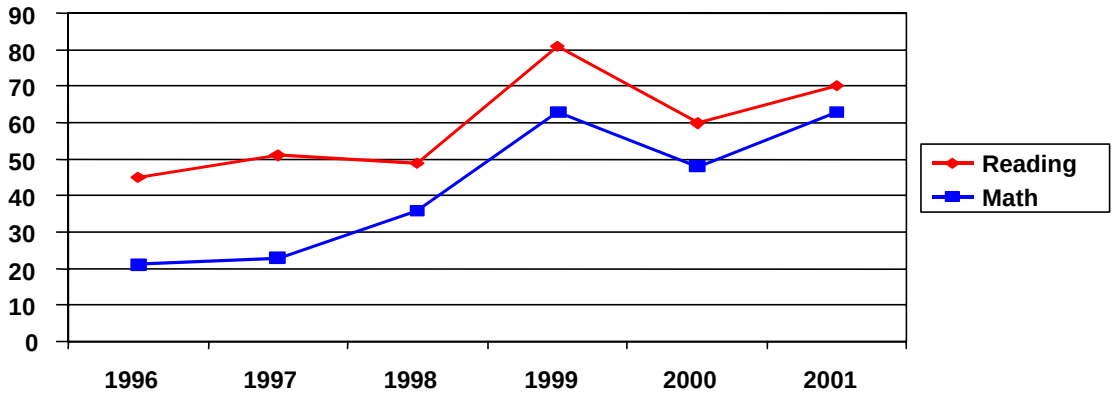


Figure 66 shows the six-year trend in the percentage of third grade students at Warm Springs Elementary School that met or exceeded the proficiency levels of the Oregon Statewide Assessment of reading and math. The overall trend since the 996-97 school year has been one of improvement, yet the most recent results have not returned to the high levels of achievement in school year 1999-00. Nevertheless, the most recent trend is up, and this has motivated teachers, staff, parents, and other stakeholders to devote greater attention to these young Indian students.

Salish-Kootenai Reservation. At the Salish-Kootenai Reservation in Montana, the only trend data available for the period of interest (1995 to present) were the number of Salish-Kootenai High School graduates for the period 1995 to 2002. (See Figure 67.) In addition, limited trend education data were available for Montana-American Indian high school graduates and high school dropouts. (See Figures 68 and 69.)

Figure 67 - Salish-Kootenai Reservation
High School Graduates, 1995-2002

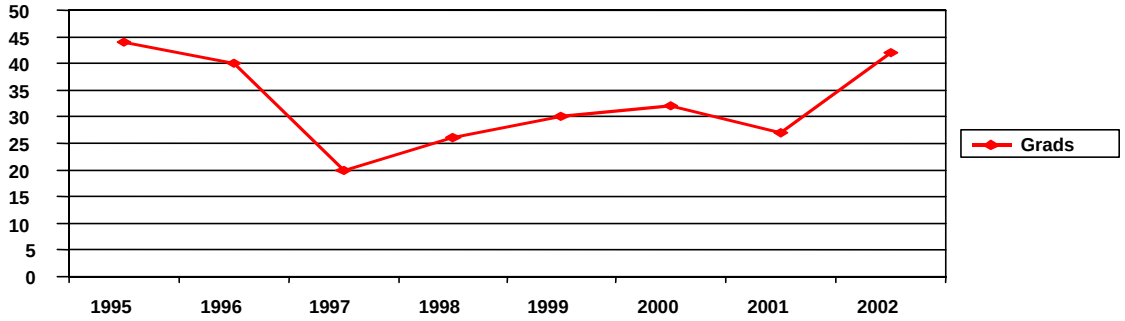


Figure 68 - Salish-Kootenai Reservation
Montana-American Indian High School Graduates
and GED Recipients, 1997-1999

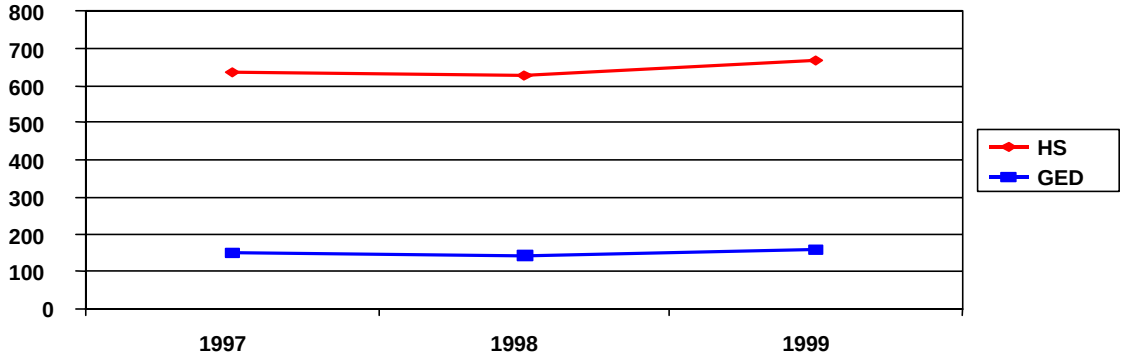
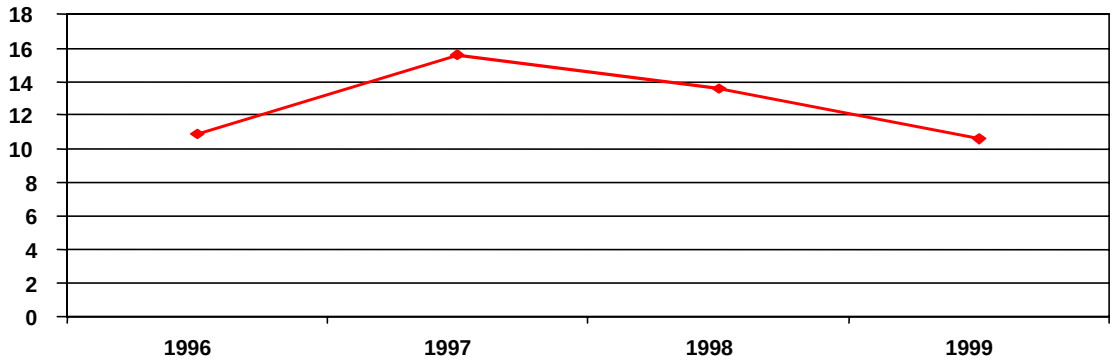


Figure 69 - Salish-Kootenai Reservation
Montana American Indian High School Dropout Rates
1996-1999



During the period 1995 to 2002, Salish-Kootenai high school graduates ranged from a low of 20 in 1997 to a high of 44 in 1995. Between 1995 and 1997, the number of graduates dropped by more than one-half. Since 1998 the trend has generally been up, with only one slight decline in 2001. Since 1998 and up to 2002, the trend in the number of high school graduates at the Salish-Kootenai Reservation has almost reached the 1995 level.

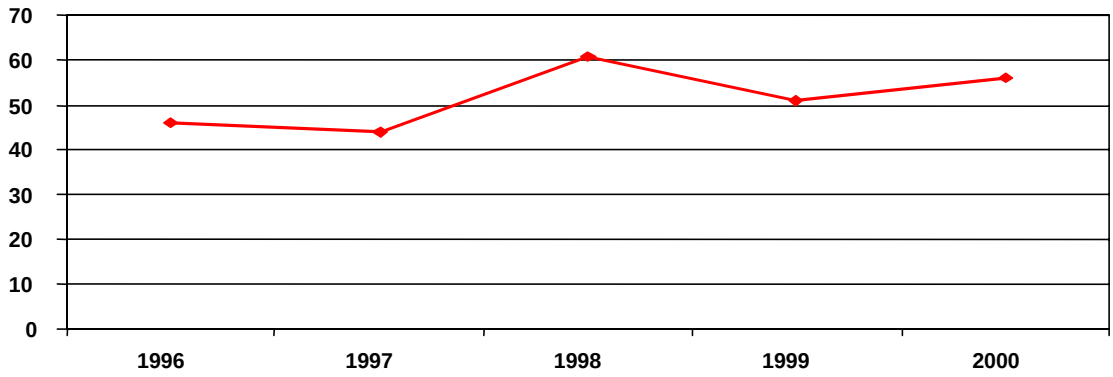
In terms of overall Montana American Indian high school graduates and GED recipients, the trend for the years 1997 through 1999 has been one of modest improvement. Between the years 1996 and 1999, the Montana American Indian high school drop-out rate has risen from 10.9 percent in 1996 to 15.6 percent in 1997 and then fallen in 1998 (13.6%) and 1999 (10.6%) to a level similar to that of 1996.

Minneapolis American Indian Center. For American Indian students in Minneapolis, school trend data were available for the number of American Indian graduates and dropouts and for the percent of American Indian students passing

the Minnesota Basic Standards Test for reading and math. Trends were favorable for each parameter.

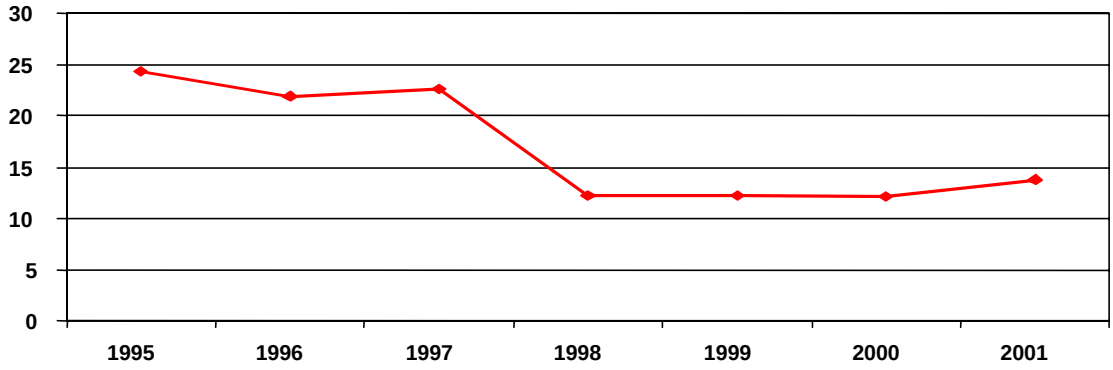
Between 1996 and 2000, the overall trend in the number of American Indian high school graduates in the Minneapolis School system was up from 46 to 56 graduates. However, in 1998 there were 61 graduates. (See Figure 70.)

Figure 70 - Minneapolis Public Schools American Indian Graduates, 1996-2000



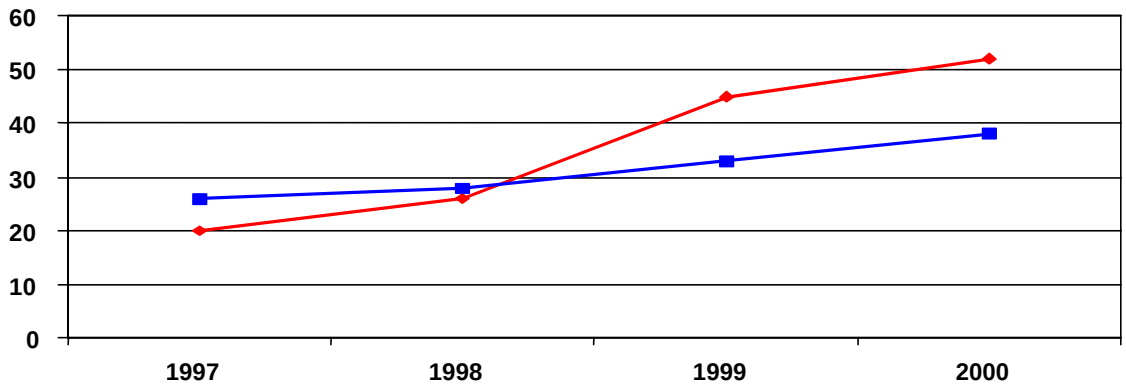
The overall trend in the percent of American Indian dropouts between 1995 and 2001 was down, from 24.4 percent in 1995 to 13.8 percent in 2001. There was an impressive reduction in dropouts between 1997 and 1998—from 22.7 percent to 12.2 percent. Since 1998 the rate of American Indian dropouts has gone up from 12.2 percent to 13.8 percent in 2001. (See Figure 71.)

Figure 71 - Minneapolis Public Schools American Indian Student Dropouts as a Percentage of Enrollment, 1995-2001



The trends in the percent of American Indian students who passed the Minnesota Basic Standards Test (MBST) for reading and math has been impressive. Between 1997 and 2000, the number of American Indian students who passed MBST for reading grew each year from 20 percent in 1997 to 52 percent in 2000. Similarly for math the percentage of American Indian students who passed increased each year from 26 percent in 1997 to 38 percent in 2000. (See Figure 72.)

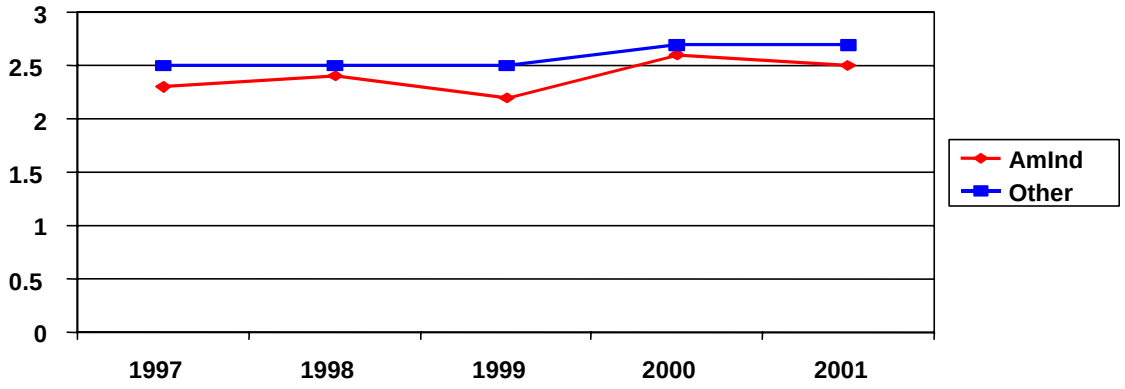
Figure 72 - Percent of American Indian Students Passing the Minnesota Basic Standards Test for Reading, 1997-2000



United Indian Health Services (UIHS). Available education data for American Indian students in the Del Norte County, California, School District who use the health services of the UIHS included annual grade-point averages; percent of American Indian high school graduates; and the rate of dropouts, participation in extracurricular activities, suspensions, and referrals for expulsions.

Between 1997 and 2001, there was modest increase in annual grade-point averages of American Indian students. In 1997 the grade-point average of Indian students was 2.3 on a 4.0 scale. It rose to a high during this period of 2.6 in 2000 and dropped slightly to 2.5 in 2001. (See Figure 73.)

Figure 73 - Annual Grade Point Averages of American Indian and Other Students, 1997-2001
United Indian Health Services, Inc.
Del Norte County, CA, School District



The overall trend in the percent of American Indian high school graduates from 1996 to 2001 was up. In 1996 the graduation rate was 57.1 percent; it reached a high during this period of 78.6 percent in 1999, dropping to 65 percent in 2000 and then rising again to 71.4 percent the following year. As shown in Figure 74, the graduation rate of American Indian students from 1996 to 2001

was about 15 to 20 percent less than that of other students, except for 1999 when the American Indian graduation rate was slightly higher than that of other students. The next year the American Indian graduation rate dropped from almost 79 percent to 65 percent, rising in 2001 to 71.4 percent.

Figure 74 - Percent of American Indian and Other Students Graduated, 1996-2001
United Indian Health Services, Inc.
Del Norte County, CA, School District

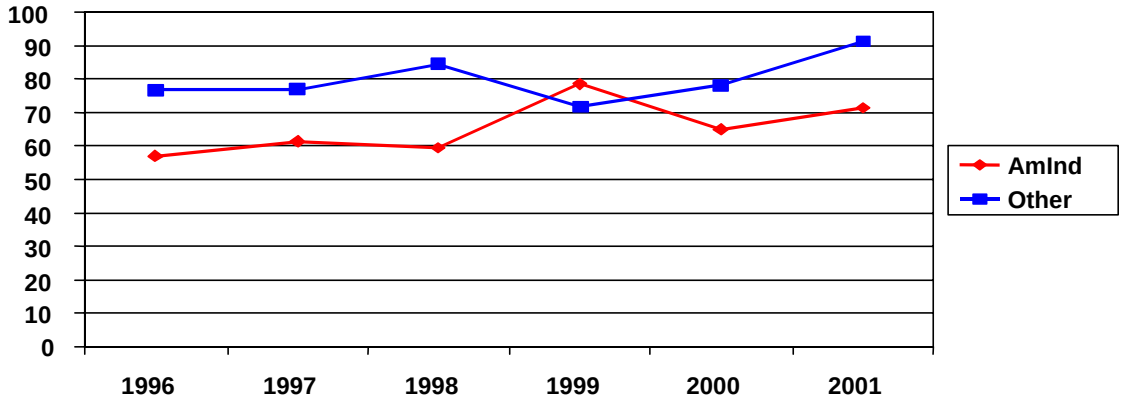
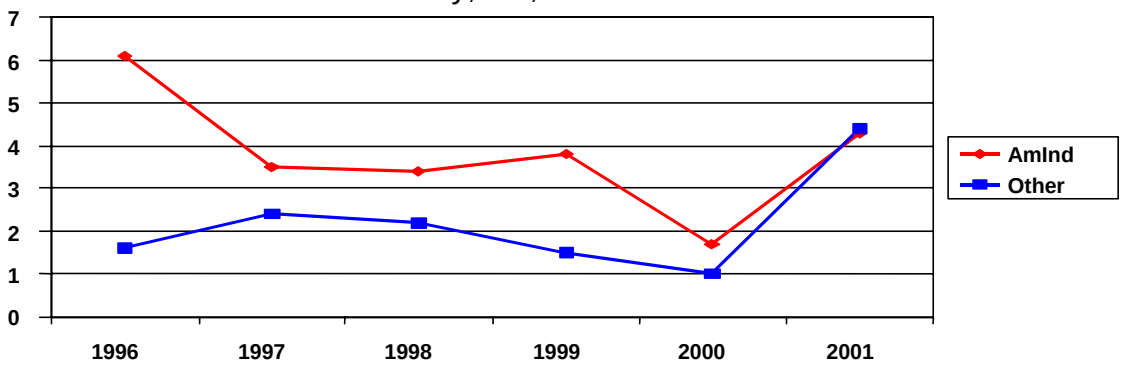


Figure 75 - Percent of American Indian and Other Student Dropouts, 1996-2001
United Indian Health Services, Inc.
Del Norte County, CA, School District



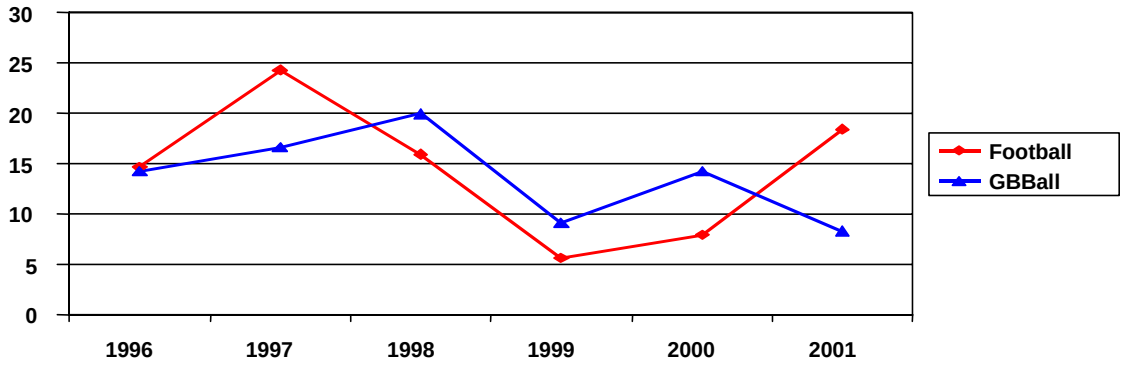
As shown in Figure 75, the overall trend in the dropout rate of American Indian students between 1996 and 2001 has been down—from a high of 6.1

percent in 1996 to a low of 1.7 percent in 2000. However, the following year the rate rose to 4.3 percent.

American Indian student participation in extracurricular sports, both football and girls basketball, has varied from year-to-year between 1996 and 2001. Overall, the trend in football participation went up in 1997 and then dropped from a high of 24.3 percent to a low of 5.6 percent in 1999. Since then the rate increased to 7.9 percent in 2000 and to 18.4 percent in 2001.

The overall trend in participation in girl's basketball has been down from 14.3 percent in 1996 to 8.3 percent in 2001. In between, the rate of participation fluctuated from a high of 20 percent in 1998, to 9.1 percent in 1999 to 14.3 percent in 2000. (See Figure 76.)

Figure 76 - American Indian Participation in Extracurricular Sports Activities, 1996-2001
United Indian Health Services, Inc.
Del Norte County, CA, School District



The rate of suspension for American Indian students between 1998 and 2001 rose to a high of 29.7 percent in 1999, dropping since then to 20.8 percent in 2000 and 19.5 percent in 2001. (See Figure 77.) The trend in the percent of American Indian students referred for expulsion was flat between 1996 and 1999, ranging between 17 and 19 percent. The rate dropped from about 19 percent in

1999 to about 8 percent in 2000. However, the rate skyrocketed to over 30 percent in 2001. (See Figure 78.)

Figure 77 - Percentage of American Indian Student Suspensions,1998-2001
United Indian Health Services, Inc.
Del Norte County, CA, School District

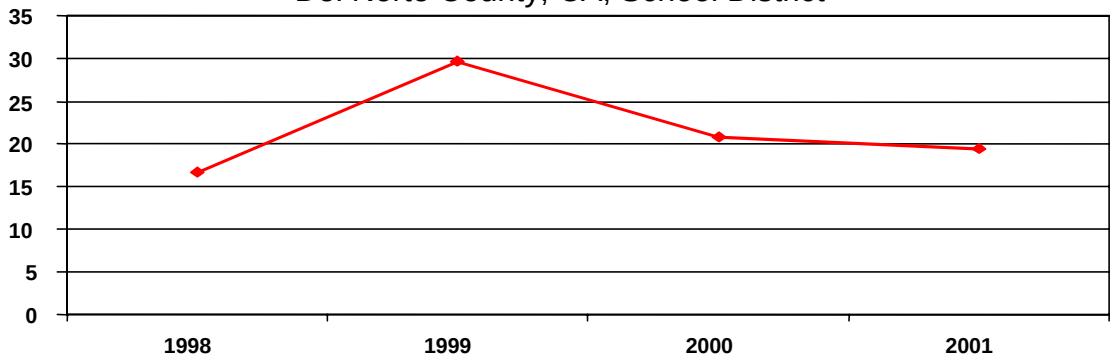
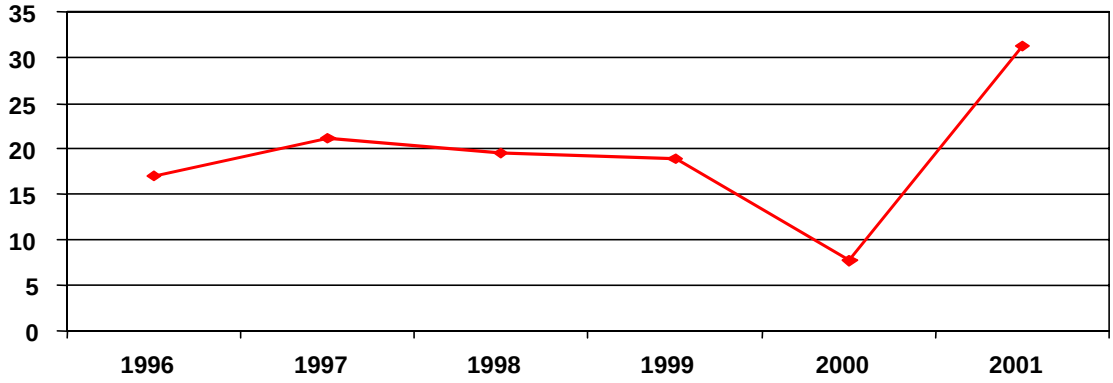


Figure 78 - Percentages of American Indian Students Referred for Expulsion, 1996
United Indian Health Services, Inc.
Del Norte County, CA, School District



HEALTH DATA

Health data were gathered from six sites. These included the Warm Springs Reservation, the Salish-Kootenai Reservation, United Indian Health Services, the Norton Sound Corporation, Northwest New Mexico Fighting Back, and the Seattle Indian Health Board.

It required an arduous series of efforts to secure permission from the first four sites listed above and from the Indian Health Service to view outpatient and hospital admissions data for the period 1995 to 2001. Once trends were calculated, it became clear that all trends were on the upswing; that is, the number of outpatient visits and hospital admissions for alcohol- and drug-related diagnoses grew, in some cases dramatically, during the period of the Healthy Nations Initiative.

In addition, health data were also gathered from the Seattle Indian Health Board and from the NW New Mexico Fighting Back program in Gallup, NM.

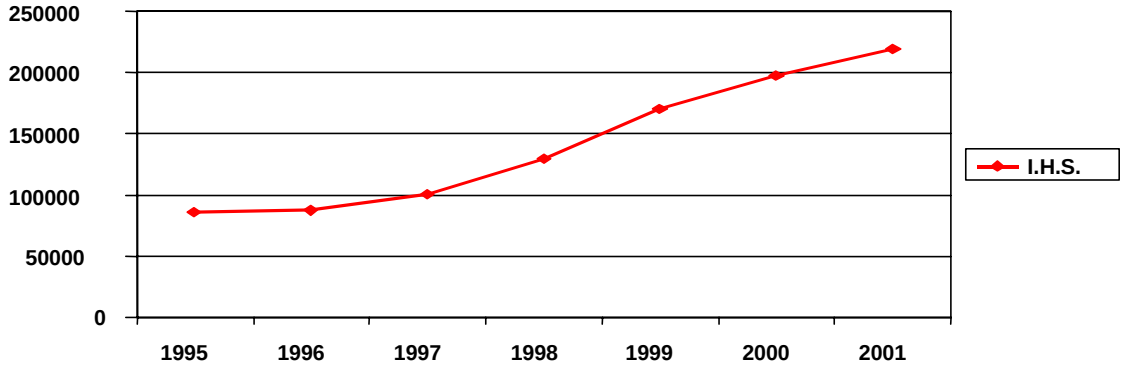
Indian Health Service patient care statistics are derived from different reporting systems. It is sufficient to say that the sources of Indian Health Service patient care information are its direct and contract care system for both inpatient and ambulatory care. All data are collected daily, with one record per hospital admission or ambulatory medical visit. The trend data viewed for this evaluation report were prepared from the National Patient Information Reporting System (NPIRS) by the Information Technology Support Center (ITSC), Albuquerque, NM. Hospitalizations and outpatient visits included inpatient visits and outpatient

visits from both the direct and contract health care delivery systems. Alcohol and drug diagnoses were comprised of the following:

- Visits with diagnoses related to alcohol present in any of nine diagnoses codes and or re-coded fields;
- Visits with the external cause of injury related to alcohol in any of nine causes of injury fields;
- Visits with the cause of diagnoses related to alcohol in any of the nine causes of diagnoses fields;
- Visits with diagnoses related to drugs present in any of nine diagnoses codes and/or re-coded field;
- Visits with the external cause of injury related to drugs.

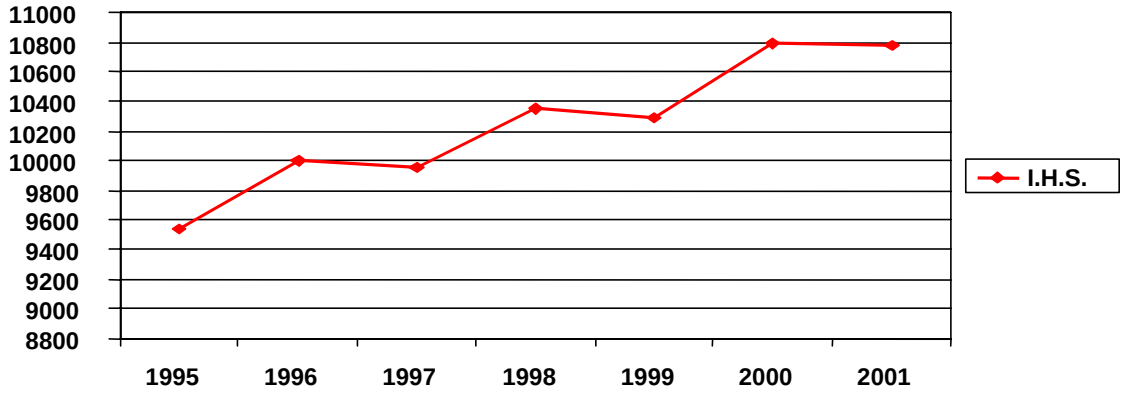
In 1995 there were 85,733 alcohol and drug outpatient visits for the entire Indian Health Service system. By 2001 there were 219,103 outpatient visits. From the 1995 level, the number of outpatient visits for alcohol and drug diagnoses grew almost two-and-one-half times. The trend shows steady growth over the period of interest. From 2000 to 2001 the number of outpatient visits grew from 197,477 visits to 219,103 visits. (See Figure 79.)

Figure 79 - Indian Health Service Alcohol and Drug Outpatient Visits, 1995-2000



Alcohol and drug hospitalizations also rose from 1995 to 2001, although at a much more modest pace. In 1996 there were 9,539 hospitalizations with alcohol and drug diagnoses. Over the period 1995 to 2001, the trend increased to 10,791 hospitalizations in 2000 before falling to 10,780 in 2001. (See Figure 80.)

Figure 80 - Indian Health Service Alcohol and Drug Hospital Admissions, 1995-2001



Warm Springs Reservation. The trend in alcohol and drug outpatient visits at the Warm Springs Reservation for the period 1995 to 2001 grew each year, although the rate of growth was much slower after 1999. (See Figure 81.) There were no alcohol or drug hospitalizations during the period of interest. In the Portland Area Indian Health Service, the organizational region in which the Warm Springs Reservation is located, the number of alcohol- and drug-related outpatient visits doubled between 1995 and 2001—from 9,573 to 20,649. The trend flattened between 1997 and 1999, but began rising again thereafter. (See Figure 82.) The number of Portland Area Indian Health Service alcohol and drug hospitalizations also grew during the period of interest. In 1995 there were 143 alcohol and drug hospitalizations. The trend was up through 1999, when there were 235 hospitalizations. The trend thereafter fell to 227 hospitalizations in 2000 and to 206 hospitalizations in 2001. (See Figure 83.)

Figure 81 - Warm Springs Reservation
Alcohol and Drug Outpatient Visits, 1995-2001

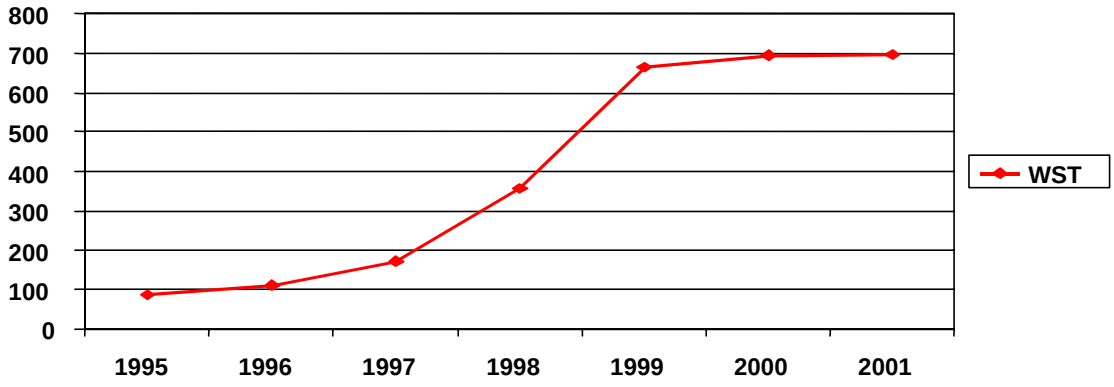


Figure 82 - Alcohol and Drug Outpatient Visits
Portland Area Indian Health Service, 1995-2001

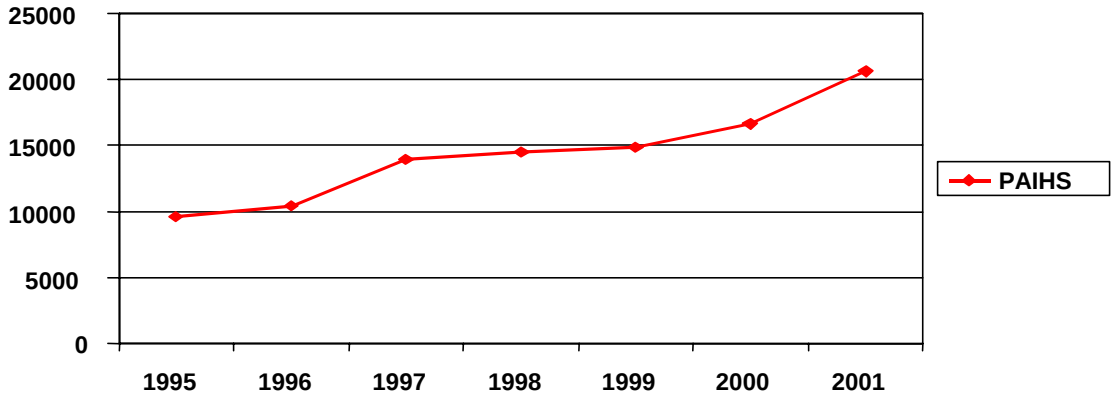
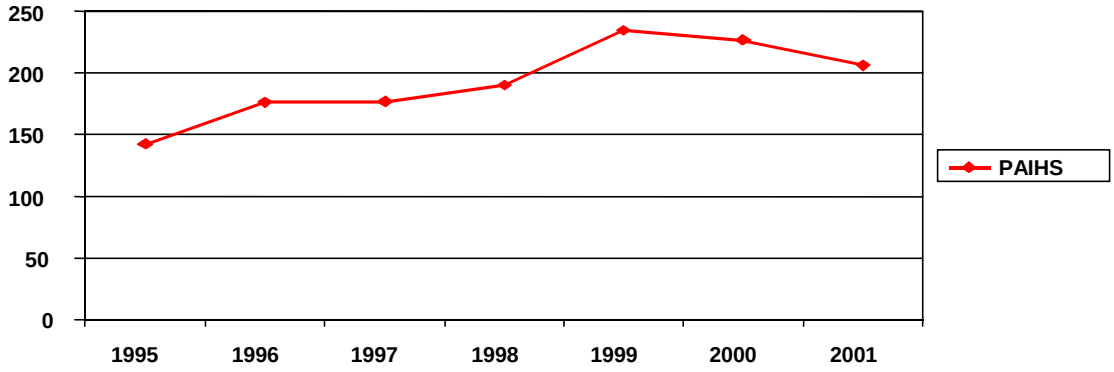
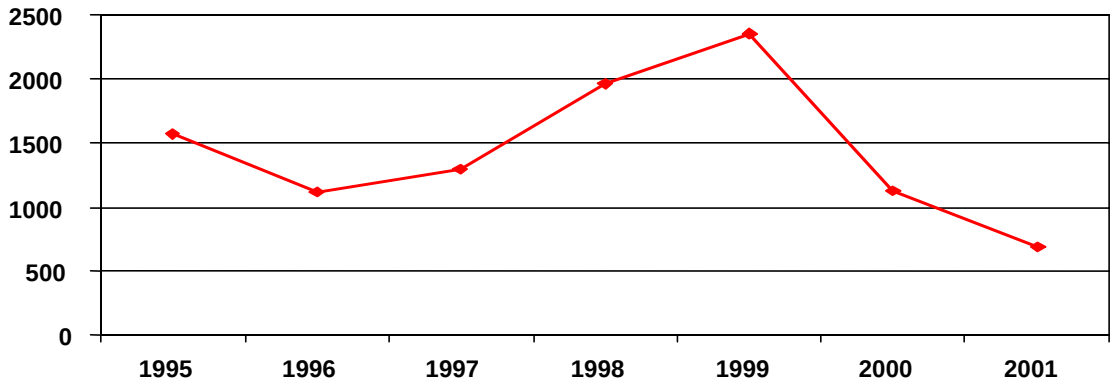


Figure 83 - Alcohol and Drug Hospital Admissions
Portland Area Indian Health Service, 1995-2001



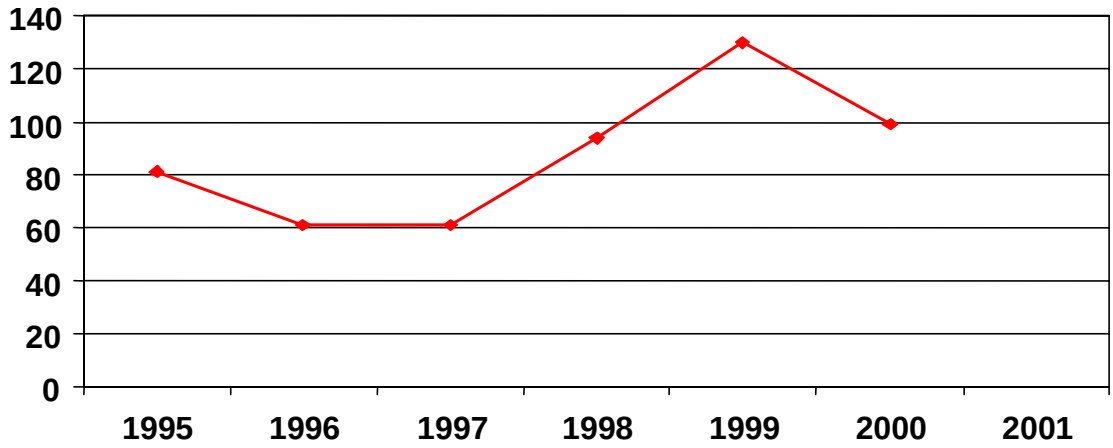
Salish-Kootenai Reservation. At the Salish-Kootenai Reservation, the trend in the number of alcohol and drug outpatient visits rose from 1,569 visits in 1995 to 2,360 outpatient visits in 1999. The trend then fell to less than one-half of what it was in 1995. By 2001 the number of alcohol- and drug-related outpatient visits had fallen to 688 visits. (See Figure 84.)

Figure 84 - Salish-Kootenai Reservation
Alcohol and Drug Outpatient Visits, 1995-2001



The overall trend in alcohol- and drug-related hospitalizations at the Salish-Kootenai Reservation was down dramatically; by 2001 there were no alcohol- or drug-related hospitalizations recorded. At the beginning of the trend period, there were 81 alcohol- and drug-related hospitalizations. The high point for the trend period was 130 alcohol and drug hospitalizations in 1999. In 2000 the number fell to 99, and then in 2001 it fell to zero. (See Figure 85.) The explanation for this decline will be discussed later.

Figure 85 -Salish-Kootenai Reservation
Alcohol and Drug Hospital Admissions, 1995-2001



In the Billings Area Indian Health Service, the Indian Health Service organizational region in which the Salish-Kootenai Reservation is located, the trend in the number of alcohol- and drug-related outpatient visits was up during the late 1990s, having more than doubled over the trend period. In 1995 there were 6,406 alcohol- and drug-related outpatient visits in the Billings area. By 2001 the number had reached 14,501. (See Figure 86.) The trend in alcohol- and drug-related hospitalizations was generally flat between 1995 and 2001, with a slight decline between 2000 and 2001. (See Figure 87.)

Figure 86 - Billings Area Indian Health Service
Alcohol and Drug Outpatient Visits, 1995-2001

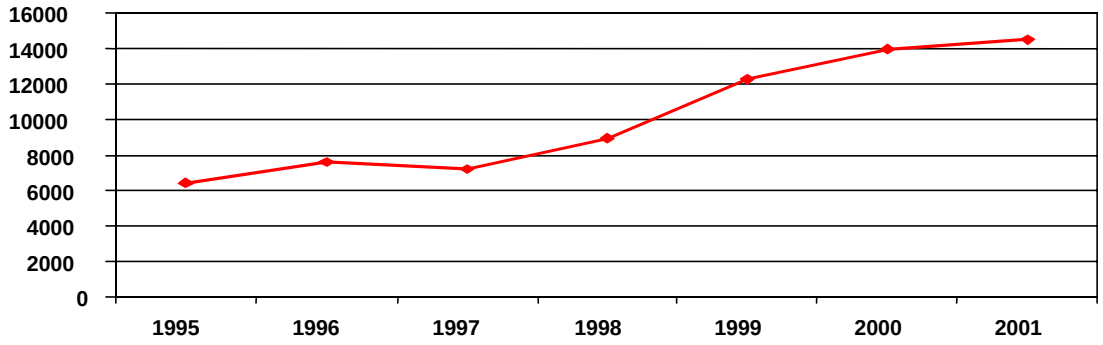
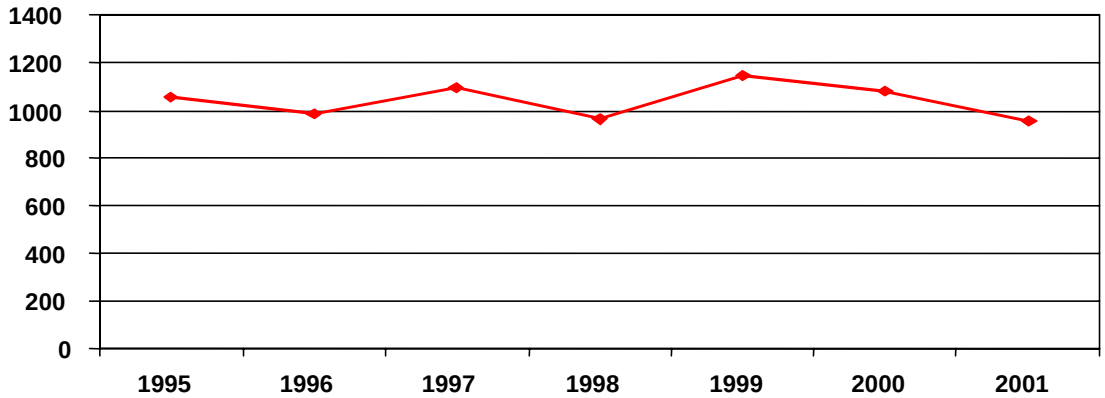


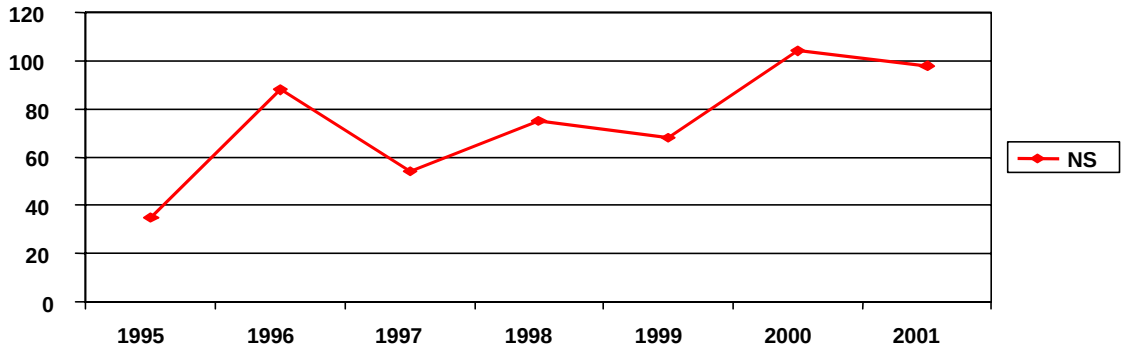
Figure 87 - Billings Area Indian Health Service
Alcohol and Drug Hospital Admissions, 1995-2001



Norton Sound Health Corporation. Because of its remote location (in and around Nome, AK) and because up until about 2001 there was no available ambulatory health service for alcohol- or drug-related health conditions, all alcohol- and drug-related diagnoses were referred to direct care or contract care hospitals.

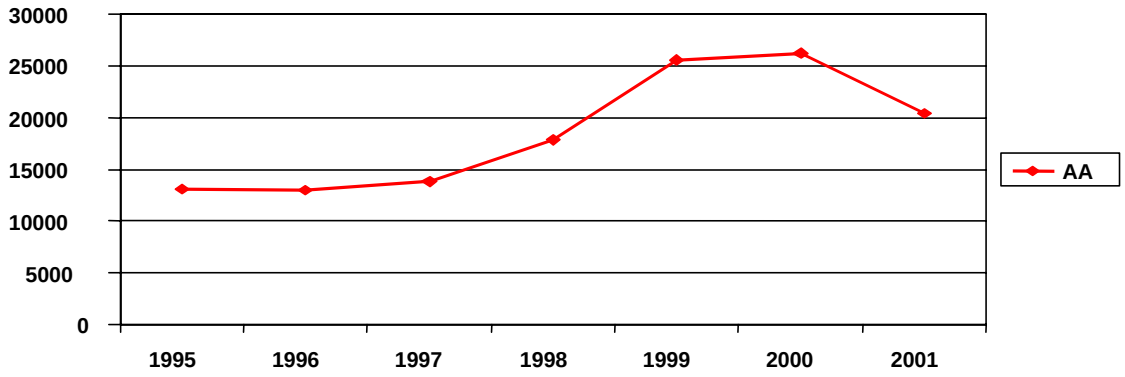
During the trend period (1995 to 2001), alcohol- and drug-related hospitalizations grew from 35 hospitalizations in 1995 to 104 in 2000, falling the year after to 98 hospitalizations. (See Figure 88.)

Figure 88 - Norton Sound Alcohol and Drug Hospital Admissions, 1995-2001



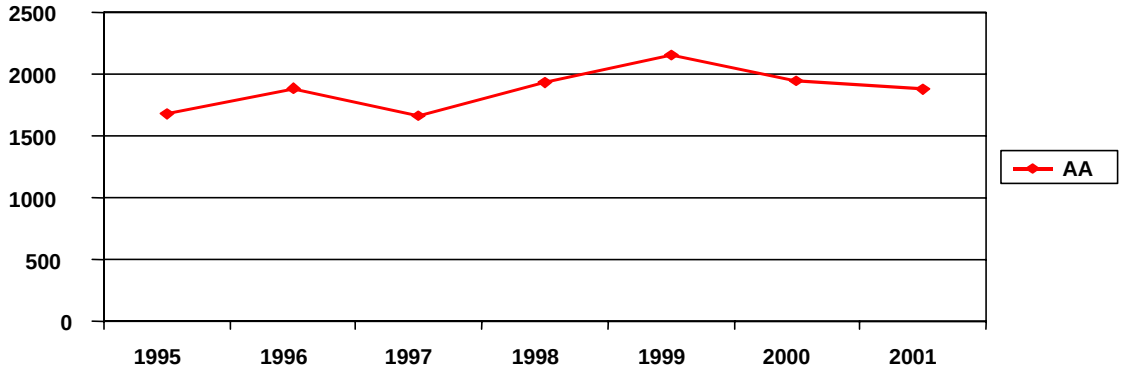
In the Alaska Area Indian Health Service, the organizational region in which the Norton Sound Health Corporation is located, alcohol- and drug-related hospitalizations grew from 1,681 hospitalizations in 1995 to a high of 2,157 in 1999. The trend fell the following two years to 1,907 hospitalizations in 2000 and 1,877 in 2001. (See Figure 89.)

Figure 89 - Alaska Area Indian Health Service
Alcohol and Drug Outpatient Visits, 1995-2001



The number of alcohol- and drug-related outpatient visits in the Alaska Area Indian Health Service grew from 13,108 visits in 1995 to a high, during the trend period, of 26,187 visits in 2000. The number of alcohol- and drug-related outpatient visits fell in 2001 to 20,423 visits. (See Figure 90.)

Figure 90 - Alaska Area Indian Health Service
Alcohol and Drug Hospital Admissions, 1995-2001

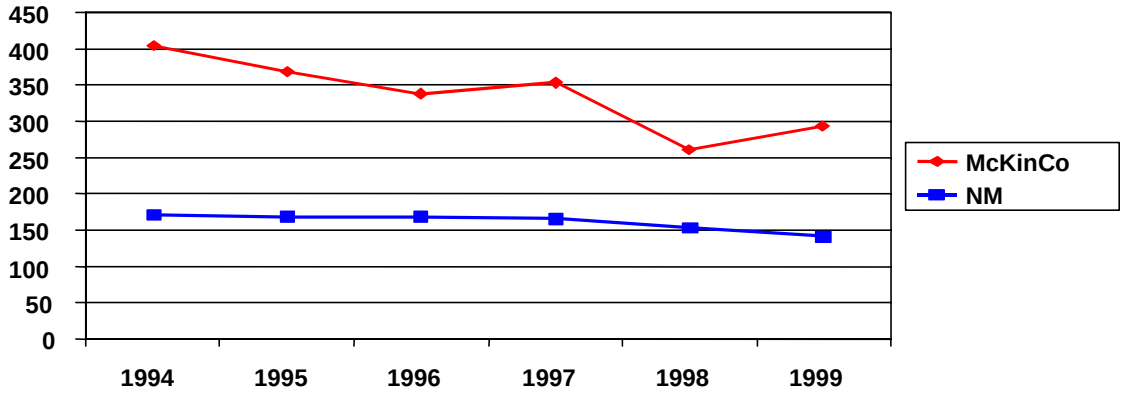


NW New Mexico Fighting Back. Health information for the NW New Mexico Fighting Back program was collected from sources other than the Indian Health Service. Those sources include the New Mexico Department of Health, Bureau of Vital Records and Health Statistics; the New Mexico Health Policy

Commission; and the Division of Government Research at the University of New Mexico. As noted earlier, information for the NW New Mexico Fighting Back program is not specific to American Indians. Available information includes alcohol-induced inpatient discharges for non-federal New Mexico hospitals for the state of New Mexico and McKinley County between 1991 and 1999; annual mortality rates for motor vehicle accidents for the state of New Mexico and McKinley County, 1974 to 1999; and alcohol-related fatal or injury traffic crash rates for the state of New Mexico and McKinley County, 1982 to 1999.

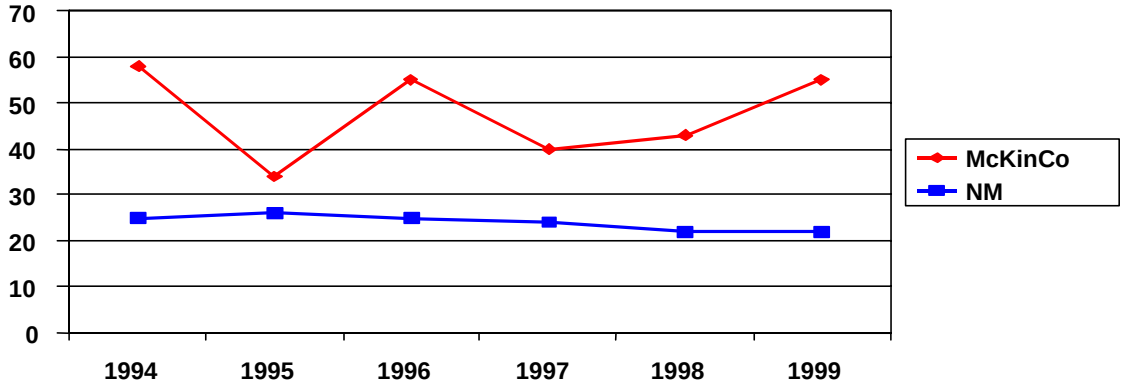
The overall trend in alcohol-induced inpatient admissions from 1994 to 1999 in McKinley County, NM, was down from 404 hospitalizations per 100,000 population at the beginning of the trend period to 294 hospitalizations per 100,000 population at the end of the trend period. In between, 1998 experienced the lowest rate. So, while the overall trend has been down, it has started to rise since 1998. For the state of New Mexico, the trend in alcohol-induced hospitalizations per 100,000 population has been down although not as markedly as that for McKinley County. The overall trend since 1994 has declined steadily each year—from 171 hospitalizations per 100,000 population to 141 in 1999. (See Figure 91.)

Figure 91 - Alcohol-Related Hospitalizations, Nonfederal New Mexico Hospitals, McKinley County and New Mexico, 1994-1999
(Discharges/100,000 Population)



The overall trends in annual mortality rates for motor vehicle accidents in McKinley County, NM, and for the state of New Mexico did not change very much from 1994 to 1999. For the state of New Mexico, the trend was fairly smooth, declining slightly from 25 deaths per 100,000 population in 1994 to 22 deaths per 100,000 in 1999. For McKinley County, the overall trend was not smooth, rising and falling throughout the trend period. The lowest annual mortality rate was in 1995 when there were 34 deaths per 100,000 population due to motor vehicle accidents. The highest rate for the period was in 1994 when there were 58 deaths per 100,000 population. Although the overall trend has been down by three fatalities, the trend rose during the last five years of the trend period. (See Figure 92.)

Figure 92 - NW New Mexico Fighting Back
Motor Vehicle Mortality Rates, McKinley County and New Mexico, 1994-1999
(Deaths/100,000 Population)

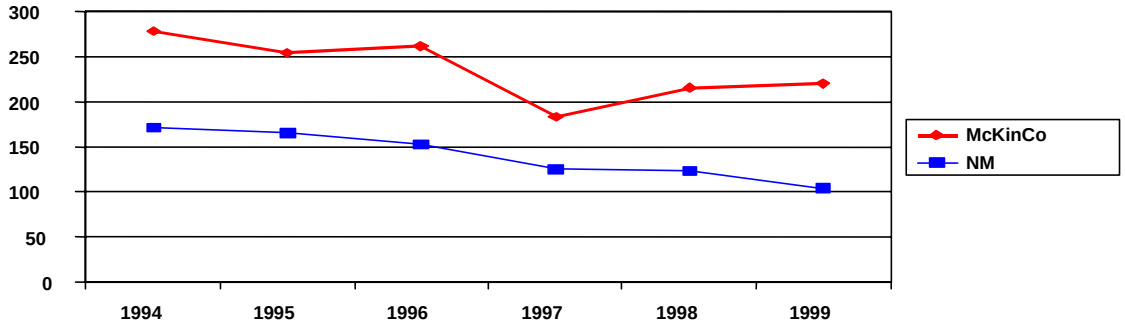


The overall trends in alcohol-related fatal or injury traffic crash rates for McKinley County and the state of New Mexico have been down. However, as with the trend in motor vehicle accidents in McKinley County, the County has seen an increased rate in alcohol-related fatal or injury traffic crashes in recent years.

For the state of New Mexico, the overall trend has been generally smooth, falling from an alcohol-related fatal or injury crash rate of 171 per 100,000 population to 104 per 100,000. The McKinley County trend was not so smooth but, nevertheless, fell from a high of 278 per 100,000 population to a low of 183 per 100,000 during the trend period. Unfortunately, since 1997 the trend has gone up. (See Figure 93.)

Figure 93 - NW New Mexico Fighting Back Alcohol-Related Fatal or Injury Traffic Crash Rate, McKinley County and New Mexico, 1994-1999

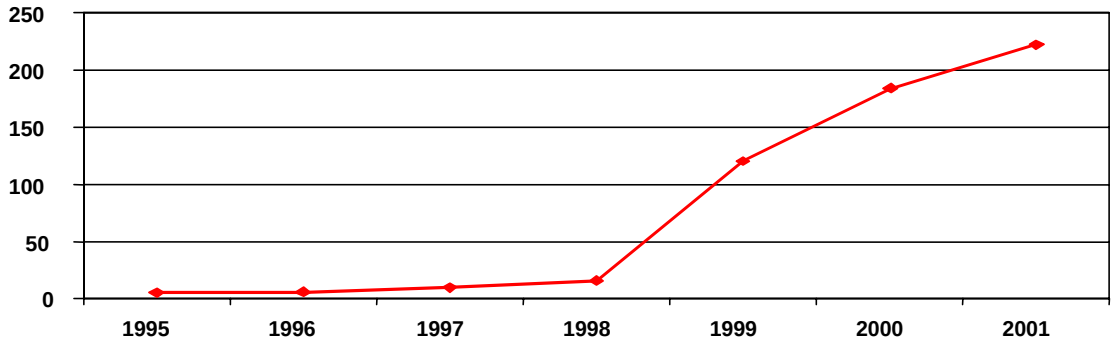
(Crashes/100,000 population)



Seattle Indian Health Board. Health information from the Seattle Indian Health Board included substance-abuse outpatient visits and Thunderbird Substance Abuse Treatment Center admissions for the period 1995 to 2002. In addition, health trend information was also available for the proportion of adolescent admissions to the Thunderbird Treatment Center from 1998 to 2002.

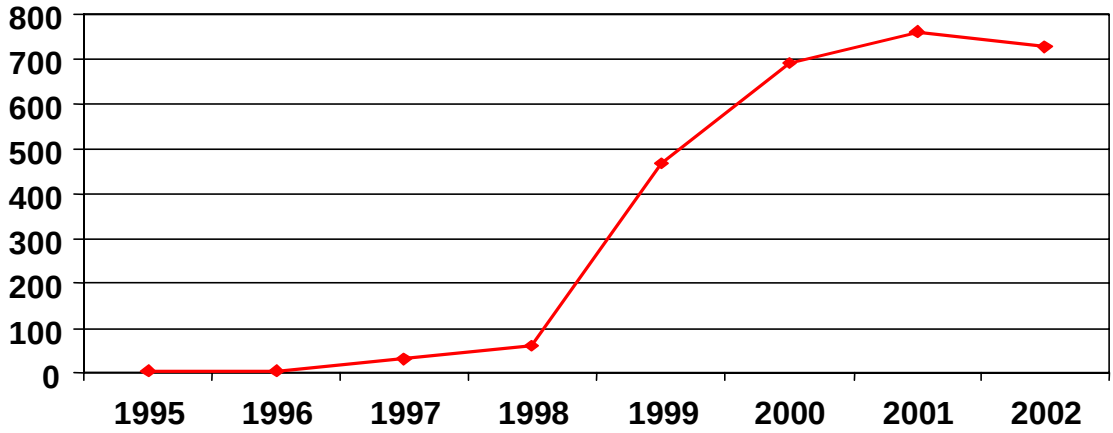
All trends were up. In fact, for substance-abuse outpatient visits and for Thunderbird Treatment Center admissions, the trends were up considerably. Between 1995 and 1998, the number of substance-abuse outpatient visits grew from 5 to 16. In the following three years, the number of substance-abuse outpatient visits grew from 120 to 184 to 222, respectively. (See Figure 94.)

Figure 94 - Seattle Indian Health Board
Substance-Abuse Outpatient Visits, 1995-2001



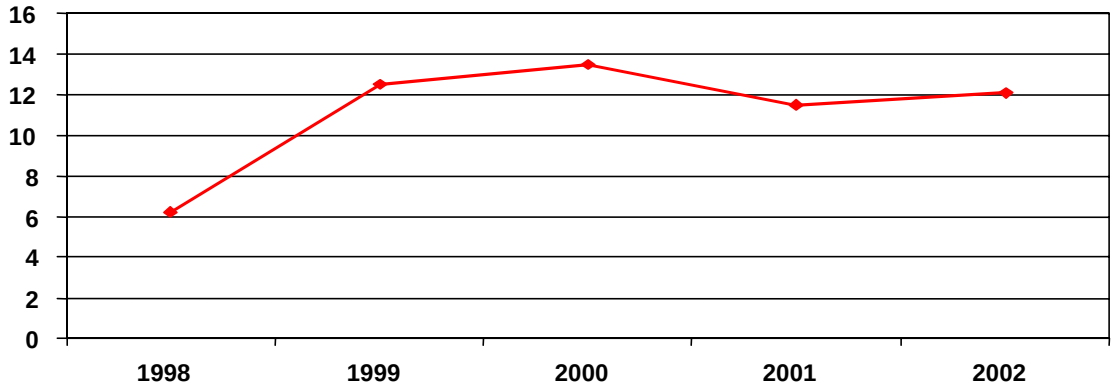
The growth in number of admissions to the Thunderbird Treatment Center was equally great. Starting in 1998 the number of admissions grew from 61 to 469 in 1999. For the rest of the trend period, the number of annual admissions to the Thunderbird Treatment Center was 691, 761, and 727, respectively. (See Figure 95.)

Figure 95 - Seattle Indian Health Board
Thunderbird Substance Abuse Treatment
Center Admissions, 1995-2002



From 1998 to 2002, the proportion of adolescent admissions to the Thunderbird Treatment Center ranged from 6.25 percent to 13.5 percent. Over the trend period, the average proportion of adolescent admissions was slightly over 11 percent and the overall trend was up. (See Figure 96.)

Figure 96 - Seattle Indian Health Board
Percent of Adolescent Admissions
Thunderbird Treatment Center, 1998-2002



United Indian Health Services, Inc. At the UIHS, located in northern California (almost in Oregon), the trends of all three health-related social indicators were up for the period 1995 to 2001. These indicators included alcohol and drug outpatient visits for UIHS and for the California Area Indian Health Service. Also available were date for alcohol and drug hospital admissions for the California Area Indian Health Service.

Alcohol and drug outpatient visits at UIHS grew dramatically from 377 visits in 1995 to almost 3,000 visits in 2001. During the same period alcohol and outpatient visits doubled in the California Area Indian Health Service, growing from 8,148 visits in 1995 to over 16,000 visits in 2001. The numbers of alcohol and drug hospital admissions for the California Area Indian Health Service were

small, ranging from a low of five admissions in 1996 to a high of nineteen in 1999. Only limited hospital and other inpatient data were available from UIHS and are not here reported. (See Figures 97, 98, and 99.)

Figure 97 - Alcohol and Drug Outpatient Visits
United Indian Health Services, Inc, 1995-2001

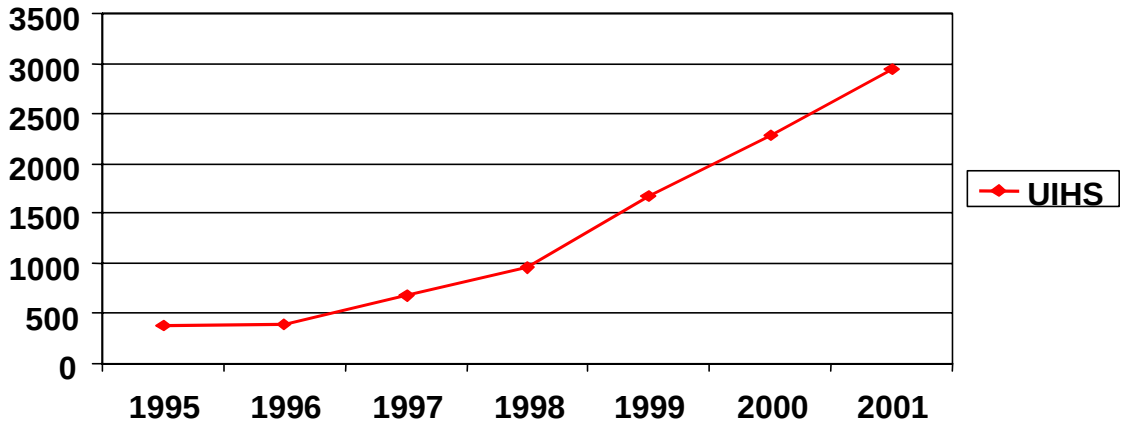


Figure 98 - Alcohol and Drug Outpatient Visits
California Area Indian Health Service, 1995-2001

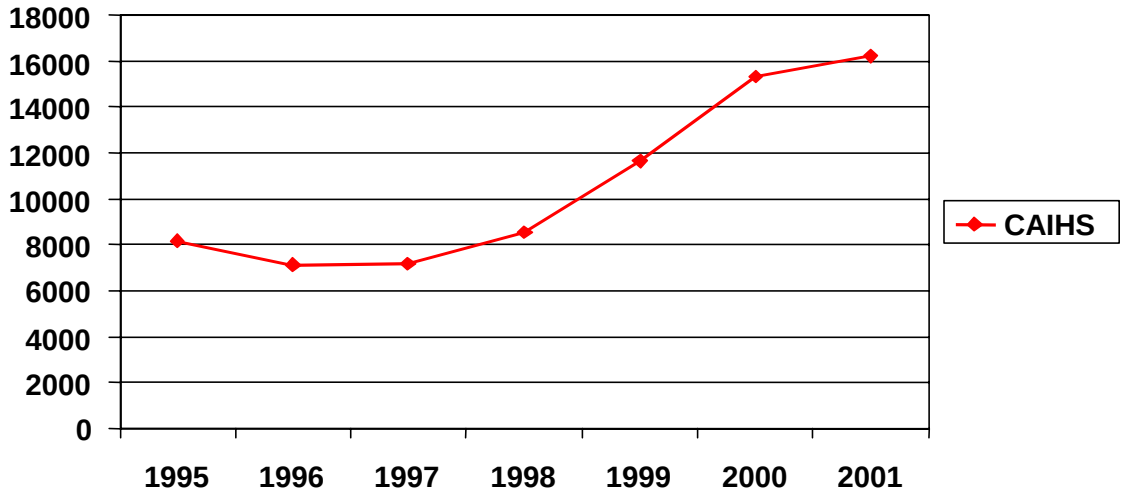
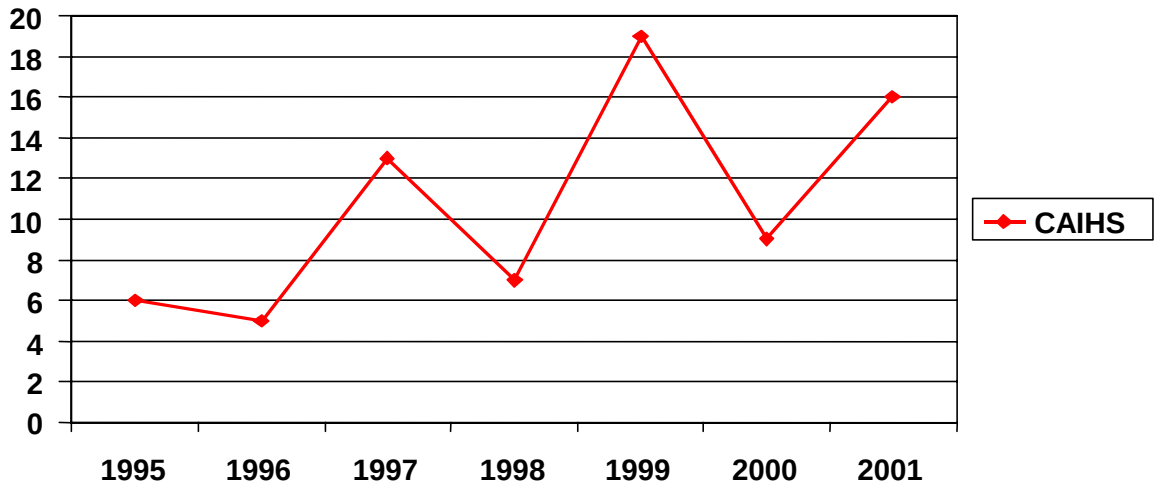


Figure 99 - Alcohol and Drug Hospital Admissions
California Area Indian Health Service, 1995-2001



Summary

On its face, assessment of social indicator trends collected and presented herein for the HNIE do not support the notion that an intervention, such as the Healthy Nations Program—or any other intervention—has had a positive influence on substance abuse among American Indians and Alaska Natives. The reason for this is that many of the trends we would like to see go down—DUI arrests, substance-abuse outpatient visits, school suspensions, and self-reported use of alcohol and illicit drugs—are, in fact, going up. Conversely, those trends we would like to see go up, such as grade-point averages and graduation rates, were either rising very modestly or were going down.

As presented, some social indicator trends seem to be going in the right direction. For example, on the Salish-Kootenai Reservation both alcohol and

drug-related outpatient visits and alcohol- and drug-related hospitalizations have been going down, especially since 1999. However, the information available is suspect because of a major disruption in the collection of health data that occurred during the late 1990s. Similarly, the YRBS-BIA health survey information collected shows clear reductions in the numbers of Indian students who report current use of alcohol, current marijuana use, and lifetime inhalant use. Yet, these data too must be critically assessed in light of the fact that a zero-tolerance policy was implemented at BIA schools during the 1990s. The net effect of this policy was that Indian youth with higher levels of substance use were less likely to be BIA school students.

Also, the seemingly good progress that took place on Warm Springs Reservation regarding law enforcement trends, such as adults and juveniles in detoxification, must take into account that there have been periods during the 1990s when there was inadequate staffing. And, it was because of inadequate staffing that lower numbers of adults and juveniles received detoxification care.

Nevertheless, there are a few bright spots. The Montana YRBS shows definite reductions in lifetime inhalant use both on reservations and in urban areas. On the Salish-Kootenai Reservation, adult substance-abuse-related arrests are down. On Warm Springs Reservation, both adult and juvenile DUI arrests have gone down since 1995.

Perhaps the most encouraging information has come from social indicator information from schools. For example, at Warm Springs Reservation, the improvement in the numbers of elementary school children meeting or exceeding

proficiency levels on the Oregon Statewide Assessment of reading and math performance has been remarkable. This achievement is directly related to the Healthy Nations resources provided to the schools and to parents for the purpose of improving their children's self-esteem and self-confidence.

As a result of the inconclusive nature of the data, I think it fairly obvious that the Healthy Nations Program required and deserved a more rigorous evaluation component. Certainly, I think, a more rigorous evaluation component, developed and implemented before the program began, would have served both the RWJ Foundation and American Indians and Alaska Native sites much better than the retrospective methods that were actually utilized.

Healthy Nations Evaluation

Drinking Behavior, Norms, and Opinions in Two Healthy Nations Sites with Two Matched Controls

by

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RWJF HNIE 353

Introduction

The Epidemiologic characteristics of drinking among American Indian adults has not been well studied and not monitored longitudinally to any extent (May, 1996). Trends in substance abuse have been monitored for Indian youth over the past two decades (Beauvais, 1998), but there is less variability in drinking among youth than among adults by various age groups and by tribal culture or community. The few studies of adult drinking among Indians have reported the following: that more men than women drink; that drinking in ages 40+ is reduced, and many males and females become abstainers; that overall about 70 percent of males and 60 percent of females among Plains tribes drink; that alcohol is perceived as a dangerous commodity, and therefore most Indians have conservative values about its use; but behavior often does not live up to these conservative values, and infrequent high-risk, severe, binge drinking is far too common among a subset of people in many reservation communities; and that binge drinking and some chronic drinking take a toll in terms of morbidity, mortality, and social consequences (May, 1996; May and Gossage, 2001).

In this chapter an attempt is made to gauge the impact of the Healthy Nations Program at two of the program sites by comparing alcohol- and drug-abuse variables to two carefully matched control reservations. Some conclusions might be made about the impact of Healthy Nations activities from this comparison.

Methods

The data in this chapter were collected under the activities of two grants (R01 AA09440 and R01 AA11685) from the National Institute on Alcohol Abuse and Alcoholism (NIAAA). As part of prevention and epidemiologic research on fetal alcohol syndrome (FAS), the data originate from a self-report survey of adults (16 years and older) in each of four communities of the Northern Plains of Montana, South Dakota, and North Dakota. The reprocessing of the data and the analysis for this part of the Healthy Nations evaluation study was funded by the Robert Wood Johnson Foundation.

All four communities in the analysis were of Plains or Plains/Plateau culture, two of which participated in the Healthy Nations initiative the entire six years of its existence and two which did not (control communities). One of the Healthy Nations communities was substantially more acculturated than the other, and one control community was also more acculturated than the other control. This makes the matching of the Healthy Nations communities with the controls quite good, as contained in each comparison group is one relatively traditional and one relatively acculturated group. As presented in Table 1, there were few differences in the demographic variables of the Healthy Nations and the control groups once the data were aggregated. This makes the comparison of drinking and drug-use variables more valid and less likely to be influenced by factors exogenous to social movements/public health initiatives such as Healthy Nations.

The first year that tribes had the legal authority to legalize alcohol on reservations was 1953. All four of the reservations have had a current and

historical pattern of legalized alcohol on reservation. The two Healthy Nations sites legalized alcohol on their reservations in 1953 and 1960, and the two controls legalized in 1955 and 1981 (May, 1977; Lopez, 2002), although given the nature of land ownership and proximity of non-Indian towns to the major Indian populations on the later reservation, legal access to alcohol has been relatively easy since 1953.

The sample is from a self-report survey of 1,519 individuals in the four communities collected between 1997 and 2000. It is the aggregate of four simple random samples from the tribal roles of the four communities and an extensive, 28-page questionnaire. Respondents had the option of filling out the questionnaire on their own or by interview in either English or their traditional language. Respondents received $10 for their time and effort. Quality control was ensured by University of New Mexico-trained and -employed staff at each site and staff based in Albuquerque. The questionnaire contained items on the quantity, frequency, and variability of drinking and drug use. It also asked about drinking contexts, norms of drinking, knowledge, attitudes, and beliefs about drinking and alcohol policy, and the consequences of drinking and drug use. The final age range in the sample was 16 to 92 years, with a mean age of 38.8 and a median of 37. The sample size at each site (n = 380) was selected to ensure less than 5 percent error, and in most sites it is estimated at 4 percent given the small population. However, the error estimates of the individual Healthy Nations sample and the control sample as presented here is 3 percent, and the overall sample combined is less than $\pm$ 2 percent.

All variables in the sample were scrutinized for relevance to the Healthy Nations program. Once the Healthy Nations comparison files were established through the reprocessing of these data, a second examination of relevant variables was again pursued. As reported in the following tables, those variables which address Healthy Nations program goals, whether with significant differences and without statistical significance, are substantial in number. Some indicate areas of encouragement, while a few are discouraging.

It would have been ideal to have had a pretest/posttest design. A survey such as this could have been administered at baseline and repeated in the sixth year of the Healthy Nations program. But that research design was not pursued by the program. However, the timeframe covered by the survey (1997-2000) on these reservations provides a snapshot of differences that might be attributed to the programs, activities, and paradigm put forth by Healthy Nations programs at these two sites.

Results

Analyses were completed for comparing data from respondents of the Healthy Nations (n = 747) and control sites (n = 774) on various demographic, cultural, substance use, and opinion variables. Demographic variables are presented in Table 1 and show that the two groups of respondents were virtually identical in the distribution of males and females (43% and 56%, respectively). Respondents within the Healthy Nations sites were 1.5 years older than respondents within the control sites (40 years of age vs. 38); this difference was near statistical significance (t = 1.93, p. = 0.054). As a group the Healthy Nations

respondents had achieved substantially more education (X^2 = 6.84, p. = 0.033). The groups were similar in marital status with 48 percent of both groups reporting they were married. The Healthy Nations group held jobs with higher status as categorized with the Hollingshead Occupational Codes with 16 percent holding professional or administrative jobs vs. 15 percent for the control group. The Healthy Nations group also included more individuals who were skilled in various manual jobs (25% vs. 21%). The difference between the two groups with respect to types of occupations was statistically significant (X^2 = 22.26, p. = 0.004). One would expect then that the mean family income among Health Nations' families would be higher, and this was the case with 24 percent having incomes greater than $30,000 as compared to 21 percent for the control sites, but this difference was not significant. One measure of social integration (Durkheim, 1951; May, 1982) is presented in Table 1 and shows that 67 percent of both groups had resided off their reservation for one year or more. Both groups provided information about their television-watching habits. The data revealed an average of three hours per day and seventeen hours each week were spent watching television; there was no significant difference in the amount of television viewed. Both groups are well below the National mean of 5 hours per day. This information has potential value in identifying favorite television shows ("Seinfeld," "E.R.," assorted news programs, and the "Wheel of Fortune") and for targeting the viewers of those favorite shows with public service announcements in which to include universal messages about the prevention of alcohol-related problems such as driving while intoxicated (DWI) or Fetal Alcohol Syndrome (FAS).

Table 1. Characteristics of the Two Samples *

Variable	Healthy Nations Sites (n = 747)	Control Sites (n = 774)
Sex (%)		
Male	43.4	43.8
Female	56.6	56.2
X^2 = 0.03, *p*. = 0.867		
Age (mean)		
t = 1.93, *p*. = 0.054	39.6	38.1
Education (%)		
<HS / GED	23.5	26.0
HS or GED	23.6	27.7
Vocational school +	52.9	46.3
X^2 = 6.84, 2 df, *p*. = 0.033		
Marital Status (%)		
Single (never married)	30.6	31.1
Married	47.7	48.2
Separated/Divorced/Widowed	21.7	20.7
X^2 = 0.23, 2 df, *p*. = 0.893		
Employment Status (%)		
Employed	54.4	58.1
X^2 = 2.15, *p*. = 0.143		
Occupations (Hollingshead Occupational Codes)(%)		
Professional or administrative jobs	16.0	14.9
Skilled manual	24.9	20.9
All others	59.1	64.2
X^2 = 22.26, 8 df, *p*. = 0.004		
Family Incomes (%)		
<$20,000	59.8	63.1
$20,000 - $29,999	16.3	16.2
$30,000 or more	23.9	20.8
X^2 = 2.21, 2 df, *p*. = 0.331		
Residence / social integration (%)		
Lived off reservation 1 year or more	67.3	66.9
X^2 = 0.03, *p*. = 0.865		

Table 1. Characteristics of the Two Samples * (continued)

Variable	Healthy Nations Sites	Control Sites
Television Watching Habits		
Hours per day (mean) t = 0.25, p. = 0.799	2.9	2.9
Hours per week (mean) t = 0.90, p. = 0.369	16.6	17.3
Favorite shows (top 3)	Seinfeld news E.R.	news Seinfeld Wheel of Fortune

* All respondents

Five measures of culture are contained in Table 2. The first is a self-assessment of how closely one holds to his or her cultural ties or adopts the habits and behaviors of the dominant society. The data revealed that respondents within the control sites identified more strongly with their Indian culture than with the White world (34% vs. 24%) (X^2 = 33.72, p. = 0.000). However, respondents within the Healthy Nations group were substantially more active in their traditional ceremonies (59% vs. 53%) (X^2 = 13.62, p. = 0.001). The difference between the two groups was more striking on a third measure. Respondents from the Healthy Nations sites were much more likely to want his or her child to have a traditional name (74 percent of Healthy Nations' respondents vs. 59 percent for control respondents, X^2 = 32.62, p. = 0.000). The two groups were virtually even in their use of traditional treatments and teas weekly or at other times. Lastly, respondents were presented with a long list of events and

ceremonies in which they may have participated (including daily prayers to sweat lodge ceremonies to give-aways). Respondents indicated by their answers that they were actively involved in many of those activities and ceremonies. There was no significant difference between the two groups on this variable.

Table 2. Cultural Measures *

Variable	Healthy Nations Sites	Control Sites
Biculturalism (%)		
Indian only	3.8	9.7
Mainly Indian	20.5	24.4
Bicultural	42.7	42.0
Mainly White	30.6	22.9
White only	2.4	1.1
X^2 = 33.72, 4 df, *p*. = 0.000		
Degree of involvement in traditional ceremonies (%)		
Somewhat active	46.6	45.4
Very active	12.2	7.1
X^2 = 13.62, 2 df, *p*. = 0.001		
As a parent, respondent wants traditional name for child (%)	73.7	59.0
X^2 = 32.62, *p*. = 0.000		
Use traditional treatments and teas (%)		
Weekly	2.4	1.4
Other times	38.9	36.1
X^2 = 1.36, *p*. = 0.243		
Participation in traditional prayers and ceremonies (%)		
(Respondents can select more than one ceremony)	220.6	243.2

* All respondents

A primary focus of the community surveys was to determine alcohol consumption behaviors to establish norms for each community. Respondents were asked to provide information about their personal consumption of alcohol within the 7 days, 30 days, and 12 months preceding their interview. Among those respondents who had consumed alcohol at some time in their lifetime, 77 to 80 percent of the men and 69 to 70 percent of the women had consumed one or more drinks within the past year; these individuals are called “current drinkers” (see Table 3). There were no significant differences between Healthy Nations and control communities on this variable. Among the current drinkers, the men on average had been “high” or drunk 28 to 29 times in the past year. The range for women was 14 to 6 times (see Table 3). The men were fairly even in the percentage of those who had consumed alcohol within the 30 days preceding their interview (76-78%). However, among the women, there was a statistically significant difference; only 56 percent of the control site women had consumed alcohol in the past 30 days as compared to 68 percent residing in the Healthy Nation sites ($X^2 = 7.86$, $p. = 0.005$). Data showed that men within the control sites had 3.3 heavy drinking days vs. 2.7 for men with the Healthy Nations group; but these differences were not significant, nor was there a difference for women as both groups reported 1.8 heavy drinking days within the past 30 days. In line with these data, men in the control group consumed more standard drinks of alcohol on the days they drank (7.5 vs. 6.8 drinks), and there was a modest difference among the women on this measure with the woman in the Healthy Nations group

consuming 5 drinks on the days in which they drank alcohol as compared to 4 drinks for the women in the control group. Neither difference was significant.

Binge drinking (consuming five or more drinks per occasion) has been identified in many studies as being a cause and correlate with alcohol-related injuries, motor vehicle crashes (May, 1996; Robin, et al., 1998), and FAS (May, et al., 2000). On this variable the data revealed a statistically significant difference for men and women. Men within the control group had four binge drinking days in the past 30 days as compared to three for men in the Healthy Nations group (t = 2.71, p. = 0.007). And women within the control site reported two binge drinking days vs. one for women in the Health Nations group (t = 2.13, p. = 0.034). Almost identical percentages of men and women consumed alcohol in the seven days preceding their interview, but there was a substantial difference among the number of drinks consumed by men during that time period. Men in the control group consumed an average of 32 drinks whereas men in the Healthy Nations group consumed 18 drinks (t = 2.23, p. = 0.026).

Table 3. Alcohol Consumption Measures

Variable	Healthy Nations Sites	Control Sites
Drank in last year (%) *		
Male	76.7	79.9
X^2 = 0.95, p. = 0.330		
Female	69.7	68.9
X^2 = 0.07, p. = 0.796		
Times “high” or drunk in last year (mean) **		

Table 3. Alcohol Consumption Measures (continued)

Variable	Healthy Nations Sites	Control Sites
Male	29.3	28.0
t = 0.24, p. = 0.810		
Female	15.8	14.0
t = 0.54, p. = 0.587		
Drank in past 30 days (%) **		
Male	78.3	76.4
X^2 = 0.27, p. = 0.604		
Female	67.6	56.0
X^2 = 7.86, p. = 0.005		
Number of heavy drinking days in past 30 days (mean) **		
Male	2.7	3.3
t = 1.15, p. = 0.253		
Female	1.8	1.8
t = 0.22, p. = 0.830		
Number of drinks consumed per day when drinking in past 30 days (mean) **		
Male	6.8	7.5
t = 1.08, p. = 0.280		
Female	4.5	4.2
t = 0.80, p. = 0.425		
Days binged (5+ drinks per occasion) in past 30 days (mean) **		
Male	2.8	4.1
t = 2.71, p. = 0.007		
Female	1.3	1.9
t = 2.13, p. = 0.034		
Drank in past 7 days (%) **		
Male	62.1	62.6
X^2 = 0.01, p. = 0.906		
Female	42.4	39.6
X^2 = 0.46, p. = 0.496		

Table 3. Alcohol Consumption Measures (continued)

Variable	Healthy Nations Sites	Control Sites
Number of drinks consumed in past 7 days (mean) **		
Male	18.0	32.3
t = 2.23, p. = 0.026		
Female	12.9	11.9
t = 0.43, p. = 0.666		

* Include respondents who have consumed alcohol at some time in their lifetime.
** Current drinkers; respondents who have consumed one or more drinks of alcohol in past 12 months.

Many problems can occur when men and women abuse alcohol; several are included in Table 4. The data reveal that respondents in the control group are more likely to drive while intoxicated (51% vs. 42%, X^2 = 7.00, *p*. = 0.008), drink alone (13% vs. 10%), and experience blackouts (23% vs. 18%, X^2 = 4.14, *p*. = 0.042). On four additional measures there is little difference between the two groups: whether respondents feel they have had major problems with alcohol, percent who have sought help in treatment, success of that treatment, and stopping and restarting drinking.

Table 4. Problems with Alcohol

Variable	Healthy Nations Sites	Control Sites
When drinking, does respondent ever (%) **		
Drive while Intoxicated	42.3	50.5
X^2 = 7.00, p. = 0.008		
Drink alone	9.8	13.2
X^2 = 2.94, p. = 0.087		
Black out	17.7	22.8
X^2 = 4.14, p. = 0.042		
Respondent has had major problem with alcohol (%) *	30.6	27.8
X^2 = 1.34, p. = 0.246		
Been in treatment (%) *	24.9	23.0
X^2 = 0.73, p. = 0.391		
Was any type of treatment helpful (%) *		
Yes	40.5	41.0
X^2 = 0.01, p. = 0.910		
In past, restarted drinking again after stopping (%) *		
No	40.3	38.9
Yes, once	23.0	21.8
Yes, more than once	36.7	39.3
X^2 = 0.80, 2df, p. = 0.669		

* Include respondents who have consumed alcohol at sometime in their lifetime
** Current drinkers

Other substances of choice are reported in Table 5. A higher percentage of control-group respondents smoke cigarettes weekly or more often (57% vs. 50%; X^2 = 12.46, p. = 0.014). And it would appear that the difference in the smoking of cigarettes is accounted for in the use of smokeless tobacco where more respondents in the Healthy Nations group use smokeless tobacco weekly or more often (12% vs. 5%; X^2 = 37.10, p. = 0.000). Use of marijuana, “speed,”

and cocaine is similar and not significant for the two groups and ranges from a high of 7 percent to a low of 3 percent.

Table 5. Other Drug Use

Variable	Healthy Nations Sites	Control Sites
In past 12 months, used weekly or more often (%)*		
Cigarettes	49.7	56.5
X^2 = 12.46, 4 df, p. = 0.014		
Smokeless tobacco	12.1	5.3
X^2 = 37.10, 4 df, p. = 0.000		
Marijuana	6.4	6.8
X^2 = 5.96, 4 df, p. = 0.202		
Used in last year (%) *		
"Speed"	7.1	7.0
X^2 = 0.00, p. = 0.948		
Cocaine	2.9	3.4
X^2 = 0.31, p. = 0.578		

* All respondents

To assist tribal councils and public health officials in identifying and targeting health and social problems within their communities, respondents were asked to give their opinion as to the seriousness of seven problems. On the first five categories (FAS, cirrhosis, suicide and suicide attempts, family violence, and sexual abuse), more respondents within the Healthy Nations group rated these problems as very or extremely serious. The differences in opinions for cirrhosis and suicide and suicide attempts were statistically significant (X^2 = 15.01, p. = 0.000 and X^2 = 6.42, p. = 0.040, respectively). On the matter of how easy it was for an individual under the age of 21 to buy alcohol, more respondents within the control group believed the problem was very or extremely serious (X^2 = 15.33, p.

= 0.000). Both groups were asked for their opinion on whether the loss of Indian culture contributes to alcohol and drug problems. On this measure, a higher percentage of respondents in the Healthy Nations group (71%) were in agreement when compared to the control group (65%) (X^2 = 5.59, *p*. = 0.018) (see Table 6).

Table 6. Opinions on Alcohol-related Health and Social Problems

Variable	Healthy Nations Sites	Control Sites
Problem is very or extremely serious (%)*		
FAS	77.1	73.7
X^2 = 3.70, 2 df, p. = 0.157		
Cirrhosis	81.9	75.8
X^2 = 15.01, 2 df, p. = 0.000		
Suicide and suicide attempts	72.1	66.0
X^2 = 6.42, 2 df, p. = 0.040		
Family violence	81.2	80.0
X^2 = 0.92, 2 df, p. = 0.632		
Sexal abuse	75.2	71.4
X^2 = 2.80, 2 df, p. = 0.246		
Easy to buy alcohol underage	71.3	78.7
X^2 = 15.33, 2 df, p. = 0.000		
Loss of Indian culture contributes to alcohol and drug problems (%) *		
Yes	70.5	64.8
X^2 = 5.59, p. = 0.018		

* All respondents

Complementing the data presented earlier on the prevalence of drinking within 7, 30 days, and last year, the respondents gave their opinion on the number of drinks it would take for the average man and woman to get drunk; these data are presented in Table 7. The data suggest a modestly higher tolerance for both men and women in the control group. For men, respondents

within the Healthy Nations group believed that a man would become drunk after consuming 7.3 drinks. That compares to 8.2 drinks for the control group (*t* = 3.19, *p*. = 0.001). Similarly, for men, respondents within the Healthy Nations group believed that a woman would become drunk after consuming 5.5 drinks. That compares to 5.9 drinks for the control group (*t* = 1.99, *p*. = 0.047).

Table 7. Norms of Heavy Drinking

Variable	Healthy Nations Sites	Control Sites
Number of drinks for a male to get drunk *		
Mean	7.3	8.2
t = 3.19, p. = 0.001		
Number of drinks for a female to get drunk *		
Mean	5.5	5.9
t = 1.99, p. = 0.047		

* All respondents

A final group of questions explored some knowledge, attitudes, and beliefs about FAS. As shown in Table 8, respondents in the Healthy Nations group were more likely to have been informed about the potential harm that could occur to the fetus if a woman consumed alcohol during her pregnancy. Modestly higher percentages of respondents in the Healthy Nations group learned of that linkage from doctors or healthcare providers, traditional healers, and grandparents. For traditional healers the difference was statistically significant (X^2 = 10.18, *p*. = 0.006). Finally, a very high percentage of both groups had heard of fetal alcohol syndrome (92% and 89%).

Table 8. Knowledge, Attitudes, and Beliefs about Fetal Alcohol Syndrome

Variable	Healthy Nations Sites	Control Sites
Informed about the effects of drinking alcohol during pregnancy via (%) *		
Doctor or healthcare provider	42.2	39.9
X^2 = 1.77, 2 df, p. = 0.414		
Traditional healer	14.5	11.0
X^2 = 10.18, 2 df, p. = 0.006		
Grandparents	30.0	26.4
X^2 = 2.96, 2 df, p. = 0.227		
Ever heard about Fetal Alcohol Syndrome or FAS (%) *		
Yes	91.6	89.4
X^2 = 2.07, 2 df, p. = 0.355		

* All respondents

Discussion

This comparison of two Healthy Nations sites with two matched control sites is theoretically a very good match. In the Healthy Nations data, one reservation is a Plains-Plateau culture with relatively high levels of acculturation, and one reservation is a more isolated and traditional Plains. The control groups are virtually identical in composition—one Plains group is acculturated; one quite traditional. Among the demographic variables, there were no major differences in the comparison groups except for slightly higher educational and occupation levels on the Healthy Nations reservations. The groups did not differ significantly by sex, education, employment/unemployment status, income, residence off-reservation, or television-watching habits. Age approached significance, with the Healthy Nations site respondents 1.5 years older than controls.

With the general equality of the comparison groups in mind, the Healthy Nations reservation respondents were more likely to report bicultural identity, yet on most measures were more active participants in traditional ceremonies and practices. Bicultural identity is reported in the literature as a protective factor against substance abuse. Did Healthy Nations foster an increased appreciation for biculturalism and for Indian ceremonies? Did Healthy Nations programs provide a greater opportunity to participate?

On alcohol consumption variables, there were limited differences, but those that exist may be very important. There was no difference in the two groups for either males or females on the following variables: the percentage who drank last year; the number of times drunk last year; the number of heavy drinking days last month, the average number of drinks on each drinking day, or percentage who drank last week. However, a higher percentage of Healthy Nations females drank last month, but they were less likely than controls to have binged. Healthy Nations males were also very significantly less likely to have binged last month and drank almost half as many drinks (usually beer) last week compared to control males. So it appears that while frequency of drinking may not have been affected by Healthy Nations, the quantity consumed per occasion was affected for males and somewhat less for females; yet binge drinking measures were significantly lower for both males and females of the Healthy Nations sites.

There are no differences in treatment experience between Healthy Nations sites and the controls, but the Healthy Nations sites report significantly

lower rates of DWI and fewer blackout episodes. Similarly, other drug use (e.g., marijuana, speed, and cocaine) does not differ across sites; cigarette use, however, is significantly lower among the Healthy Nations sites. Smokeless tobacco use is higher at Healthy Nations sites.

Healthy Nations sites have more conservative opinions about alcohol use as they see cirrhosis, suicide, and underage purchase of alcohol as greater problems. Very importantly from a Healthy Nations point of view, the Healthy Nations respondents were much more likely to link loss of Indian culture to alcohol and drug problems. Healthy Nations programs very strongly identify traditional values with the protection of people from alcohol and drug misuse.

Similarly, Healthy Nations respondents showed more conservative norms as they reported much lower levels of alcohol consumption as linked to drunkenness for both males and females.

Finally, Healthy Nations sites reported equal levels of information on FAS emanating from healthcare providers and relatives, and they were equally likely to know about FAS. But they were more likely to have been informed about FAS from a traditional healer.

Conclusions

Without pre-program, baseline information on these variables from which to determine magnitude of change, it is impossible to link these differences directly to the Healthy Nations activities. However, most of the variables on which differences were found were those emphasized by Healthy Nations. The program

encouraged participation in traditional ceremonies for alcohol- and drug-abuse prevention; the program emphasized abstinence and/or moderation of drinking practices; and reducing the harm from alcohol use were all themes of Healthy Nations communities. Almost all of the variables cluster in these areas, which lends support to the efficacy of the Healthy Nations Initiative. Furthermore, since there were virtually no major demographic or socioeconomic differences between the two large samples, one can be more confident that there is at least a perceptual or normative difference in these two groups, some of which may be attributable to the RWJ Healthy Nations activities.

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Lessons Learned

Patterns Arising From Diversity

LESSONS LEARNED

Throughout the Healthy Nations Initiative (NHI) projects, each site developed responses to the four target components—public awareness, community-wide prevention, early identification and treatment, and aftercare options—outlined in the call for proposals. Notwithstanding the unique qualities and cultures of the grantees, there were many shared similarities and patterns in the development and execution of most, if not all, of the Healthy Nations sites. Some of these similarities can be explained due to common factors regarding the institutionalization of governmental processes learned by Native populations and organizations over years of exposure. Such patterns arise from the education of most of the directors, again reflecting the educational system at large. Further explanation for these patterns arises from years of prescriptive program development that has dominated federal grants and federal and state governmental relationships toward American Indian communities.

Lastly, one must recognize that the HNI itself had a somewhat prescriptive nature in the articulation and demands concerning the four outlined components. This prescriptive nature was most evident during the Phase I period and the first two years of Phase II. During this period most directors noted, and the documentation substantiated, considerable and exacting attention to addressing each target area was emphasized over unique local/cultural adaptations. Later emphasis allowed far more flexibility in addressing these four areas. These latter adaptations reflected more local culture and conditions.

The above is an attempt to articulate some of the reasons for the patterns arising; many of the lessons learned are more principle-based with latter site-specific adaptations. These principles, and the activities that grew from them, defined the mobilization and the impact of HNI. The outcomes of applying these principles are, not by necessity, all positive. Some lessons grew from conflict and tension while others exacted pain and anguish from both the NPO and the grantees. Many others, though, are lessons that were anticipated with hope and realized in the natural evolution of the project regardless of where and by whom. In total, the lessons and patterns reveal processes and junctures that can be translated to a smoother implementation of future opportunities.

Following the description of the patterns and lessons, I will attempt to offer some interpretation of them from the overall context of HNI. I will also make suggestions about how the particular pattern could inform new grants as they venture into working in Indian country. These patterns may inform those seeking to advance substance-abuse-related programs within Native American communities. There is probably nothing absolutely unique about these patterns or the suggestions. The power lies in the fact that the processes underlying their discovery or creation are one of community ownership and site-specific adaptation. To witness the fruition of even small increments of reclamation of culture, hope, and enthusiasm from the fabric of some of these communities is gratifying and encouraging.

Local Leadership

Few sites maintained a single director throughout the entire two phases. While this situation demonstrated the ideal, it serves as both a contrast and benchmark. Generally, the most successful projects, regardless of where and how funded, relied on strong, visionary, and talented leadership. This principle was proved again by this project. HNI did not explicitly set out to invest in or to develop individual leadership and local talent. Almost as an assumed outcome, leadership was not listed on the RWJF program roster. This lack of targeted support and planning around leadership created opportunity and frustration throughout the grant cycle. The overarching management philosophy placed HNI programs under local control. What ensued indicated that insufficient resources were allocated to maturing this important component. Under this arrangement, the assignment of directors by the tribal leadership supported the self-determination philosophy and the arms-length relationship that the NPO exercised with each governing body. While consistent and true to the attitude of HNI about dictating specific programming and process components, it did foster a stop/start pattern in program evolution. As one director amply stated after taking over the program in year 3 of phase II, “I told our governing (tribal) board that they had missed a grand opportunity.”

Many of the early directors were unfamiliar with the processes of working with a private foundation. The cultural difference, although mitigated by the expertise of the NPO, between usual governmental line-item programming and this new RWJF community-empowerment model experienced early and frequent

strains. During Phase I and early Phase II, most site visits were attempts by the NPO and NAC to motivate programs toward better reporting compliance, financial recording, and addressing the four Initiative components. Many of these meetings were perceived as threatening the funding stream. Some of them were. For the directors and each HNI site staff, fear of losing the grant dollars consumed much energy. Likewise, fear of lost funding increased political pressure from tribal or organizational leadership on HNI directors and staff and sometimes resulted in personnel changes. Some of the changes were forced from the top down while many resulted from personal frustration and reaction. Unfortunately, this proved to undermine the nature of many projects during the grant. This changing leadership landscape resulted in an ambiguous map of the site programs, especially the guiding principles underscoring HNI. Each leadership change, whether at program or governmental level, shifted the allocation of resources, the focus of attention, and the interpretation of the goals. Defensive stances, protective measures, and positive documentation became the primary foci instead of the institutionalization of infrastructure and mobilization philosophies.

Many directors were young and inexperienced. The NPO attempted to address the leadership issues in the semi-annual grantee meetings and the site visits. Many directors noted that the structure of the grantee meetings was such that their needs of sharing “Indian” style were not routinely met. The actual or perceived task of presentation and preparation diminished the possible effectiveness of these gatherings. There was a formalism that contrasted with

unspoken needs and more open sharing that were enunciated only in later years or after the fact. The defensive posture and need to present the most positive product resulted in lost opportunities to address directly the individual issues of each site.

The grantee meetings, for the most part, served to introduce novel ideas and facilitated some program cross-fertilization but generally were reported as falling short of constructing a lattice work of grantee directors. One director commented that it felt competitive in the poster sessions; another stated that the intensity and demands were burdensome; while another spoke of feeling resentful that more personal weekends were consumed in the life of HNI. Most directors recognized the positive intent and efforts of the NPO, NAC and grantee meeting committee while acknowledging different levels of support available at these meetings. The constant changing of directors contributed to the less-than-optimal effectiveness of the grantee meetings. Consonant with the effect of such changes at each individual site, the personnel changes disrupted the abilities to form the lattice work of site leaders envisioned by the NPO. The loss of history of the program caused by the introduction of each new participant at the grantee meetings separated some programs from essential relationships and dictated a slower pace of evolution and leadership development.

Likewise, site visits, especially early on, were interpreted more as technically oriented and procedural rather than personnel and program supportive. Some sites described them as “heavy handed.” Again, most sites experienced a sense of urgency for satisfying documentation and reporting

requirements. This early focus taught discipline and accountability but somewhat at the cost of stabilizing personnel, honing the visions, and attacking implementation barriers and challenges. As was the case across most sites, grantee leadership responded more acutely according to fear or political alignment. This created disconnects and re-visioning during site visits and often highlighted significant deficits in the understanding of the principles and directions of HNI by new directors, staff, and governing bodies. As in many grant-funded projects, leadership changes made the HNI somewhat ahistorical, creating a stop/start mobilization process. The leadership problem—the difficulty of retaining directors and staff—plagued the project and underscored a central focus for increased support.

Governmental organization and influence were important factors. We can see a difference between those on reservations or small communities and those from larger organizational, urban structures. All sites struggled with components of leadership and responsibility issues, but in the reservation and remote sites, changes in the political wind often meant significant changes in direct leadership of HNI. Most sites witnessed at least two changes in the governing leadership of the tribe or parent organization. Priorities changed; political favoritism prompted leadership changes; and HNI became engulfed in the rush to survive under the new governmental organization. This created a precarious thread of programming and philosophy for many sites. Under these conditions and the nature of historical reporting rationale, an area where more “reporting” requirements should have been directly translated for the grantee into intra-

agency and tribal support, directors were reticent to express struggles and need for help in order not to draw attention and prompt a site visit. Especially early in the grant cycle, this would sometimes precipitate leadership changes. The fact that most HNI leadership was not given an influential administrative location within the governmental bodies, further exacerbated this cascade of events. HNI in some sites was placed in third- or fourth-tier-management levels creating an even greater influence void and an increased susceptibility to changes in the governmental structures and, therefore, programming directions.

"Burn out" became a factor for many HNI staff. The internal struggle with tribal organizational changes, politicized funding priorities, and the perception of increased HNI program demands, particularly in the first four years, left some directors strained and vulnerable. Because of the limited personnel resources at many of the sites, successful directors were recruited to do other work outside HNI. Leadership growth and program success many times meant overwork. Over time and through the struggles associated with HNI, local leadership grew and many of the directors arose to prominence through success, endurance, and opportunities and have become significant leaders within the tribal communities.

HNI leadership growth is paradoxical. While interfering with the evolution of specific site programs or components, the loss of HNI personnel did reap some global benefit. Today, many of these ex-directors and staff occupy significant positions in tribal and community organizations. There are vice-presidents, tribal program managers, school principals, and board members who share and have implemented the HNI philosophy and exert ongoing impact in

their communities. Such a noted outcome, that has an ongoing possibility to shape the future, may well be the major long-term impact of the Initiative. Balancing the cost of individual program components as well as the frustration quotient for those involved with the more global contribution to greater community should be explicitly studied.

Human Resources

Beyond just the directors and HNI staff, each community realized significant benefit from the project. Volunteerism and activity coordinators from within each community gained valuable experience, community recognition, and management skills. Local individuals with a community focus and unrecognized leadership qualities are never totally absent in Indian Country. The nature of indigenous cultures is the fact that social structure is sustained on unheralded and hidden natural leadership. Some HNI programs tapped into this pool of resources. Through flexible funding of local ideas and culturally appropriate activities (food, gifts, etc.), the natural leadership, especially during the latter stages of HNI, emerged from the community. Giving voice through financial support and program development, many HNI directors and staff nourished local talent and cultural spokespersons. Community change is only effective from the grassroots, and all parties eventually were able to articulate and facilitate this paradigm. Traditional voices such as elders, youth, and other concerned citizens are generally drowned out by visiting experts, centralized idea brokering, and outside modeling. Even when the experts are Indian, research results and urban

models—different from the cultural context—often dictate approved activities and, more insidiously, pre-select desired outcomes. HNI evolved in such a way as to dispense, in part, with the expert model and privileged academic ideas. Interestingly, the structure of the HNI grant both limited and stimulated this growth. The four prescribed areas carried an intrinsic logic model, pre-selection of outcomes, and activity rationale. On the face, they necessitated a connection and internal theory of change between the target area and the activities. Many times, local ideas lacked this explicit connection but, nevertheless, produced intended and similar outcomes. Likewise, many of the more powerful effects are not readily measurable or describable in written quarterly reports, especially given the *post hoc* analysis employed. The local human resources developed through HNI are durable and perpetuating assets. The opportunities and legitimization offered by HNI to community shapers and embedded leaders continue to mold the community attitude toward wellness and health. Human resources discovery, growth, and support constitute much of the more robust institutionalized outcomes of the Initiative. This principle of supporting natural leaders paid great dividend to those sites and should be a more-discussed aspect of possible and powerful outcomes in any future programs.

Flexible Funding

Flexible funding proved to be significantly important. Given the history of governmental program prescription and line-item accountability, the contrast demonstrates one genius of the HNI. Although it took considerable time and

effort to shake loose from these historical constraints and conditioned learning, most HNI sites funded items and activities that previously could never get past finance departments, let alone granting agencies. This latter-stage financing structure and attitude represented a significant cultural departure for both RWJF and an unexpected change for the tribes. To the credit of RWJF and the NPO, “outside-the-box” funding of activities was allowed and eventually encouraged. This process did not run smoothly, and the call for better communication and oversight from the Foundation in helping the NPO, site directors, and tribal governing bodies negotiate the conditioned barriers was noted in more than one interview. Nevertheless, the overwhelming success of flexible funding is unprecedented. Providing food for gatherings, tee shirts for participants, money for horse feed, computers for families, feathers, leathers and beads, speakers and dancers, and tuition for training are just some of the unique and potent uses of the money. Consistent with community ownership, HNI staff attempted to provide reasonable monetary support for local cultural ideas and needs. At a few sites this financial freedom turned into a sense of unstructured license threatening the partnership that the Foundation had intended and negotiated. NPO reaction was, therefore, to restrict uses of grant funds in those circumscribed situations. This increased pressure on the directors and programs through political avenues. The first years appeared as a global reaction to the few sites that confused freedom with license. As the sites and leadership clarified their different interpretations of the financial accountability and uses of the funds, the restrictions became more targeted for those sites. Eventually, the funding

structure reached a balance between historical cost centers and novel and responsive financing.

The recent and threatening Federal government position of fraud and abuse surrounding use of funds was not the prevailing intent. As HNI matured, the flexible funding attitude encouraged creativity and local empowerment. This attitude, through time-tested relationship with the NPO, engendered trust, created seed resources for novel projects, and demonstrated a flexibility lacking in traditional funding mechanisms. Experience would conclude that some of the funds were not used appropriately and, at times, ill-advisedly, but instead of targeting that minority of uses, the NPO and RWJF seemed to grow more committed to the flexibility and creativity of latter-stage HNI financing.

One downside to this funding mechanism and attitude is that, even today, communities who were supported in their efforts, but lacking in resources, inquire about funding possibilities. HNI set a standard that no other source has risen to match. Tribal governments, federal grants, and most private grants severely limit the use of funds to explicitly circumscribed programs and program components. Many directors lamented that this rich but limited resource of HNI, when discontinued, created a significant slowing of community change, a flagging of enthusiasm, and a silencing of some natural voices, or at least substantially reduced forums where traditional voices were showcased, heard and attributed status. Many ex-directors and tribal offices still field calls asking for some support for ideas generated within the community. The dialogue about flex funding has

found some audience in select governing bodies. This principle, however, does live on through those ex-directors guiding new programs.

National Advisory Committee

In the usual fashion of RWJF, a strong and expert National Advisory Committee (NAC) was selected and invited to participate. Their role preceded the release of the RFP and was active during the winnowing of potential sites and into the developmental and implementation phases of the HNI. The experience and understanding of issues for Native people could not have been better represented. Nevertheless, there was confusion surrounding their role and relationship to the grantee sites. Directors indicated that the knowledge, energy, and utility of the NAC were not exploited sufficiently. Questions abounded about how to approach them, what to expect from them, and even the appropriateness of doing so. Some indicated that they felt that the NAC was to support the NPO while others were less certain about any role. All suggested that the NAC could have been involved more advantageously than was the case.

NAC members—but not all NAC members due in part to scheduling, time commitments, rural settings, and travel requirements—frequently accompanied the NPO staff on site visits. They attended the Grantee meetings but were usually not featured. Only a few of the directors indicated telephone or electronic communication with a NAC member. This is perplexing and is a weakness. These experts held needed wisdom in a relationship that the NPO could not occupy. One director suggested that an a single and assigned “NAC mentor

would have been great." Some directors questioned building a relationship due to the inconsistency of site assignments among the NAC. Whatever the reason, the NAC was not as important to the grantee sites as could have been or was wished. A more defined role and the assignment of a particular NAC member to a single site as a mentor would have broadened the relationship, provided a separate and stabilizing force, and offered a wealth of leadership supports to the sites, program leadership development and liaison to the grant administration.

National Program Office

The NPO served multifaceted roles. As consultants to RWJF headquarters, developers of the grant implementation processes, compliance administrators, and liaisons between the cultures and enforcers of accountability and responsibility, the NPO seemed poised to be misunderstood. From this list of roles, it is no surprise that some confusion and aggravation followed their relationships with the grantees. The NPO contained a world-class group of researchers, academics, and Native American experts with connections and history with most of the sites. Strong personalities and high expectation characterized the NPO. Early patterns of relationships between the NPO and the grantees indicated tension and frustration. Trying to monitor and hold accountable while mentoring and directing was complicated and difficult for the NPO. The goal was not to dictate the evolution of the HNI but rather to guide and encourage. This met with less-than-optimal success in the initial stages of the grant. The first four years appeared to be a learning process and experience for

both the NPO and grantee sites. The NPO demonstrated great patience with many sites as they translated the RWJF culture to the sites and vice versa. Admirably, the NPO balanced the forces and expectations of both parties through uncharted intersections of cultures, visions, and contextual realities. The NPO brokered the cultural understanding and helped to locate mutual intersections and lessons. Helping the sites report their activities was difficult and consuming. Added to that was negotiating the financial reporting necessary for any grant. Many directors indicated a suspicion about disclosing difficulties to the NPO. Each site noted areas of struggles and failures, many in politically demanding situations, that, in retrospect, they felt would have been easier to negotiate and resolve if the relationship with the NPO had been different. The confusion was between the mentoring and monitoring roles of the NPO. The tribe and the NPO, more accustomed to a monitoring role, therefore limited the relationship to one of tension and sometimes antagonism, which often exists in grant/contract structures.

This was not the intent or purpose of the NPO. Rather, it was an outgrowth of the context and history in which HNI developed. The NPO was a victim of conditioned learning, reflexive expectations, and multiple roles. As time went on, with some changes in the NPO, maturing on the part of the grantees, and greater insight on the part of RJWF, the relationship evolved into a mentoring and supportive role. This situation supports the conclusion of the leadership section: A more explicit mentoring arrangement outside of monitoring would have been preferable.

Culture as the Theory of Change

Cultural reclamation has become so discussed and pronounced as the savior of Native people that the true power is often lost in hyperbole. It seems so natural and indisputable to engage culture that we neglect articulating or documenting their actions and effects. The HNI privileged culture in a manner unlike most other programs. Without transforming culture and traditions into tools of intervention, HNI allowed important cultural and traditional strengths of grantee's community life to arise from the current bearers of such traditions. It was important to allow the living cultural traits to be situated within contemporary time and space. Unique to HNI is the pattern of culture infusion across all sites. The "hows" of implementation defined the different and site-specific cultural applications. Linking the activities directly to a logic model addressing substance-abuse prevention and treatment would fall short of explaining the effects of culture. HNI demonstrated the ability of cultural and traditional activities, over time, to infuse diverse community arrangements with a sense of commonality and connections. The barriers that were overcome did not address all the challenges inherent to cultural reclamation. Many communities, especially those sites constituted of more than one tribal people (confederated tribes, urban Indian sites, and multi-site grantees), experienced resistance and sometimes vociferous objection to instituting or participating in "traditional" ceremonies or activities. Some objected on grounds of not paralleling their personal understanding or specific tribal traditions. Others suggested that the reclamation countered their Christian conversion. Still others resisted partly out of fears of

regression in their struggle for acculturation and acceptance. This posed a challenge and growth opportunity for grantees. Most sites found more neutral or less ceremonial activities drew the most robust response over time.

Cultural backgrounds and histories also played an interesting part in meetings and operations of grantee gatherings. Open ceremonies reflected the spiritual nature and openness of Native People. Meetings were routinely opened with inclusion activities and prayers representing different religious and spiritual orientations. This is very different from meetings in most secular and academic settings. Highlighting the cultural fabric was the complementary ease with which spiritual, cultural, and procedural information was combined seamlessly in the presentations and planning of activities. A refreshing lack of political correctness in concerns of beliefs and identity surrounded many of the activities. HNI gave support and validity to such open exchange and demonstration, thereby solidifying the legitimacy of being “Indian” in mainstream forums. Such respect transferred from RWJF and the NPO to the grantee directors and staff sustained a two-world existence through understanding and, more importantly, participation by those outside this cultural context.

HNI sought to move culture from the silent and private universal background to a position of vibrant foreground. As previously stated, HNI attempted to avoid objectifying and manipulating culture by way of making it a tool of change; rather it privileged cultural and “tradition” as the best nourishing context—an irrefutable force not to be obscured or controlled. HNI acted as a stimulus for partial cultural reclamation by allowing grantee sites to integrate

tradition with western procedures. Many sites invested their resources in cultural activities, especially those targeting youth. The disconnect between the elders and youth was articulated and responded to by each site. The trajectory of this reconnection took different routes but, in the end, acted as reclamation of traditions within the communities. Explicit programs structuring elder/youth encounters in determined circumstances occurred at many sites. Other programs were less direct. Diversions programs, genealogical curiosity, hunting parties, and adopt-a-grandparent acted to connect the elders and youth. Traditional sports, tribal youth leadership courses, and dance and drumming groups were components of cultural maintenance and reclamation, substance-abuse prevention, and health-protective interventions. Culture, as many directors voiced it, was the “medicine” to apply to the sickness of substance and alcohol abuse.

Linking the messages of prevention research with traditional wisdom and cultural understanding evolved as the most potent vehicle of education and early intervention. HNI allowed the communities to shape the prevention message and utilize a familiar mechanism to deliver that message. A trans-generational effect unfolded through this process. Strong messages of identity and pride grew for and from elders, adults, and youth. The stronger pattern effects came from embedded messages instead of blatant pronouncements about prevention. Acknowledgments, cultural associations, and efforts to bridge the two worlds of the youth bore the most plentiful fruit. Early in the HNI, efforts toward community prevention and public awareness had a more direct anti-drug campaign tactic. As the different sites evolved, the methods of how to disseminate information

became less formal and more wellness oriented and included greater cultural participation. This is an important pattern that emerged across all sites.

Transforming Activities To Principles

During the first four years, the HNI directors placed great emphasis on each Initiative component. Separate programming attempted to address each area and was undertaken by each site. HNI became another branch on the tree of services at each site. Efforts were made to develop and maintain unique programs associated with HNI. Herein lies another contradiction of the granting structure. Although two of the components required involvement in direct intervention, the financial structure prohibited use of funds for direct interventions. Some of the directors mentioned that this was a confounding problem. All sites had previously established clinical services models and agencies funded by other financial sources, and most sites experienced attempts to absorb HNI into these existing structures. Many directors spoke of their struggles trying to avoid being swallowed up by their service sector. They also expressed their frustration with the insistence and NPO requirements to explicitly address intervention and aftercare. Remaining separate but gaining influence into decision making at the clinical level proved alienating during the first years. At these sites, this tension created a divide between HNI and established tribal providers. The clash of philosophies, i.e. community informed versus clinically driven, proved, at times, too devastating to foster meaningful collaboration and significantly diminished the important mutual sharing. Other sites created

adjunctive activities that were either grafted onto existing programs or depicted in ways to fulfill the required attention to the component. Eventually, the sites stimulated programming that reflected the intent of the call for proposal and was consistent with the embraced community philosophy. Youth activities, cultural camps, hikes, drumming, and such events were supported by HNI. Early on, these presented a confound. These did not usually fall within the generally understood definition of intervention and aftercare—at least clinical models. More than just a semantic difference, it was not until the last two years that most sites and the NPO advanced a more flexible definition of intervention and aftercare. Cultural activities that were adjunctive were now seen as equally potent as the western models. This constituted one of the most significant philosophical transformations of HNI. The sites demonstrated that supporting the community and their attempts to address substance abuse through nonprofessional routes proved additive and complementary to existing systems of care. Many of the institutionalized aspects of HNI reflect this transformation and subsequent inclusion into the structure and application of interventions.

The intersection of the clinical models and prevention focus of HNI clarified the tension between these two models. Those sites that initially employed clinically trained directors responded to the grant requirements with agency-based perspectives and generally had less community direction. Those that hired less professionally and clinically prepared individuals faced the historical pressure to become responsive to clinical needs, again at the expense of community. Natural evolution of all programs leads to less clinically oriented or

academically sanctioned solutions. The voice of the community, punctuated with widespread support and participation, became a major force informing the last two years. Eventually, the HNI philosophy infiltrated the fundamental fabric of services within the site. This transformation of stand-alone programming resulted in a more global mixing and apportionment of resources and attention. A two-world view of the solution arose and remains in most grantee sites.

Sustainability

From the first, sustainability was a marker for both grant inclusion and program success. As with most grants, the intent was to stimulate a substantial change that would elicit support and demand perpetuation. Encouragement to address the projection of Healthy Nations or its components into the future was included in the call for proposal. In the background of many meetings and technical support site visits was the message of institutionalizing the particular activity. The formative analysis of each site indicates that the last two years were the most productive and successful. Stability and leadership seemed more integrated at each site, in particular, during this period. Just as the program was experiencing the peak of its impact, the funding ended. The prospect of individual activities being taken over from within the host organization was diminished by the program's maturity timing. Without sufficient "peak" time to become a community expectation or having proved irrefutable organizational worth, which was an original premise anticipated in the HNI vision of the future, many of the activities died along with the funding. Those programs and activities that enjoyed

a longer successful exposure to the community were, for the most part, institutionalized.

The evolutionary pattern of the early years would predict such a current resources-limited existence for most activities. Even though most programs extended their program via no-cost extensions, sustainability was recalcitrant. Reality in Native communities is that grant money dictates a substantial portion of services and infrastructure. Outside of basic services and economic development, a majority of the sites utilize granting to survive. The statistics indicate that the level of services is below that of the dominate society. Grants, therefore, fill voids and many times create shifts in service direction as dictated by the funding agencies. This posed a significant challenge for the sustainability of Healthy Nations.

Most tribal governments were unable to commit to the level of activities enjoyed during the HNI. Finding other grants to propel Healthy Nations activities into the future required both energy and time. Both of those commodities were preciously in limited supply for most directors. Grant writing and receiving are talent intensive functions for which many of the directors had limited exposure and opportunity to acquire. Support from associated agencies or tribal entities were short in coming. The competition for survival drove the pursuit of grant funding instead of a modeled logic of sustainability. Some sites did leverage their association with Robert Wood Johnson Foundation to procure other funding. In no case was the money as flexible or available to community-informed activities. Some activities ended with being sponsored by outside agencies or transformed

into the targets of the new grant. While not fatal to every program component, such significant changes in the direction and philosophy of these activities distorted the trajectory of Healthy Nations.

Little technical support was offered to the grantee sites to pursue sustainability. Although an expectation and a tacit message, formal planning and resource identification were lacking. More than one director mentioned frustration at not receiving more concrete directions, help, or clear explanations of HNI sustainability concepts. Emotional reactions to the end of the programs were common and indicated a commitment frustrated by limited resources. Again, the NPO had a naturalistic stance in witnessing the tribal or organizational response to the end of funding. Previously, many of the governing bodies had interacted with the NPO in simply trying to avoid losing the funds. There is scant evidence that efforts were made to convince these same bodies to extend their limited resources into these HNI components. While some organizations certainly did, most quickly moved their focus to the next grant subject, thus failing to seize an opportunity to exercise the expertise and strength of the NPO and NAC. The directors were consumed in documenting the program accomplishments and looking for new jobs. Further, one director mused about the possible positive outcomes of having the Foundation mediate with other granting agencies, including the government, to help extend the life of Healthy Nations. The musing was curious but potentially a viable suggestion worthy of serious consideration. Sustainability was bounded by the progression of each site toward a demonstration of worth and effectiveness. The length of the grant, unusual and

exemplary, was insufficient to create a momentum strong enough to maintain a whole program survival. Sustainability became a mosaic of activities and, primarily, philosophies grafted into the next iteration of targeted funding. The New Mexico Fighting Back site demonstrated, both statistically and philosophical stability, that length of granting on a consistent theme with adequate flexibility resulted in more permanent programming.

Evaluation

The experience of assembling this evaluation taught a great lesson. Most sites reported only being vaguely aware that any sort of evaluation or outcome assessment was going to take place. As cited in Dr. Taylor's section, challenges and barriers to completing any formal data collection and evaluation were strongly present. For the qualitative sections, directors needed assurance that right/wrong, good/bad judgments were not going to be leveled. Most were anxious to have their story told and have lessons and patterns gleaned from their efforts. Formal evaluation, the kind that requires evidence that the "needle on the outcome measures moved," was not provided by RWJ and it was not desired nor expected by many of the HNI sites or personnel. Without explicit, measurable outcome targets and instructions to be able to demonstrate such movement, the HNI project is difficult to evaluate. Sites were encouraged to describe the activities conducted, addressing the four Initiative components without the burden of outlining the explicit intent or effect. During the interviews, most directors indicated that people had been positively impacted, but the nature and

actual results of such impacts were, at best, speculative, and subjective. This is a weakness of the project.

Unquestionably, the final evaluation product that you are reading is not the type arranged for in the last two years of the project. Many intervening variables had more than likely diminished the recollections and evaluations. Nevertheless, if the project would have been initially structured with evaluation as an expectation, arguments for extension, institutionalization, re-funding, and retrospective evaluation would have been made easier. This critique of the project is more valid for the quantitative sections, but it also applies to any formative evaluation.

The exclusion of any formal evaluation component until the last two years has a wisdom known only to those who decided. Reported discussions, opinions, and challenges to formal assessment were completed at RWJF and with the NPO. There was an early call for proposal for an evaluation component that was deemed too structured, costly, and possibly stifling to the intended creativity and evolutionary hope of HNI. It is true that many Native communities are weary and frustrated by research and statistical portraits of their lives. The lack of evaluation possibly liberated natural forces, many described in this document. The informative perspective created from a more non-judgmental position is refreshing and important. The narratives of each site are glimpses of the formation of Healthy Nations. Inferential data and shadows of measurement are the results. Probably, a combination of formal and natural evaluation could be instituted. Without making evaluation a burden or allowing data points to occupy

the focus of such a project, the teaching to the test phenomenon, having an explicit contract to help the Foundation to understand the impact of their investment seems essential.

Place In the Tribal Organization

Evidences from the narratives support the conclusion that placement in the organizational chart was directly related to the success of implementation of Healthy Nations programs. Most sites experienced both favorable and unfavorable attention from leaders such as tribal chairpersons and department directors over the duration of the HNI. During times in which a positive relationship was present, programs seemed to gain hold. This can be explained in part through a decline in internal competition for Healthy Nations resources. The protective nature of leadership association liberated project staff energies toward establishing the programs. Where applicable, all sites experienced a change in direct up-line leadership. These transitional periods often were accompanied by a change in Healthy Nations directorship changes. As priorities, philosophies, and objectives of each new community administration or government were unfolding, Healthy Nations underwent periods of re-entrenchment and re-directioning. For those that were left more exposed by their placement in sub-categories of the organizational charts, the iterations of the program were more extreme. The prospect of resisting challenges to the programming choices, attempts to divert funds into other projects, or the hopes of

sustainability were greatly diminished. Placement in prominent organizational positions offered more stability and coordination.

The negative aspect of such placement revolved around politics. More than one site experienced the leveraging of Healthy Nations for political reasons. The fallout of this kind of political co-opting led to alienation of some sectors of the service population. In some cases, the program was ostracized from the main body of related programs.

Successful programs and effective ideas draw close associations and elicit loyalty and serve as prime targets for political maneuvering. Healthy Nations experienced both the positive and less-desirable aspects of close association with authority. Although disruptive by way of political susceptibility, the organizational placement produced greater stability and more access to power centers. Working to place similar programs in higher positions in organizational charts and with greater governing board contact will ensure a more successful trajectory of future projects. Fortunately and confirming a sensed reality, the grass-root support, belief in, and voice for the HNI projects permitted the overarching philosophy and vision of HNI to survive and grow among the political winds and changes.

Summary

The lessons learned are many. Patterns can be deciphered through analysis of the cycles and efforts surrounding the Healthy Nations Initiative. A long-term view is necessary to realize the evolution of community prevention and

positive outcomes. The age-old wisdom of good leadership remains true for this project. Strong, visionary, and supported leaders created the most lasting program components and philosophies. Such leadership qualities were present at all levels of the Initiative. Length of funding positively impacted that outcome. When the goal is community change, the guiding factor must be that “time is essential in the healing.” Realizing the limited resource base inherent in Native communities, granting agencies embracing such global objectives need to exhibit endurance in providing resources for such projects. Flexibility must accompany such lengthy commitment. Truly listening to the community, privileging local culture, and instigating a grassroots health revolution demands “out-of-the-box” thinking and, therefore, funding. Willingness to invest in ideas unproved, pay for consumables, and subsidize what seems like supported employment began to emerge as wise and visionary. Surrendering the hegemony of theory to the sweat of pragmatics is a leap of faith, but one that Healthy Nations began to demonstrate as sensible and prudent.

Healthy Nations started as just another grant program. The first four years proved that breaking away from old standards is very difficult. Phase I and two years of Phase II were a developmental stage of individuation and separation from old paradigms and outside dictation of services and models of health. Following this four-year struggle with its expected stops and starts, the programs entered into a maturing phase. The similarity between sites in the content of program components belies the striking differences that the context and culture played in their manifestation. This is particularly true with the selected

participants and their interpretations regarding the program's meaning and application. No evaluation instrument can adequately or fully measure the single life touched or the community spirit renewed through Healthy Nations. One marked accomplishment was the recognition by tribal leadership around the Initiative and its importance while the project was underway.

Although most specific programs stimulated by Healthy Nations did not survive the end of funding, the ideas, hopes, and philosophy of community empowerment and strength undeniably infiltrated the fabric of service provision. These principles are demonstrated in the institutionalized behaviors exhibited by the tribes, agencies, and communities. Such incarnate ideas are the substance-free pow-wows now sponsored by many of the tribes. Community events honoring culture, youth activities, and safe and healthy lifestyles increased or were made stronger. Drug-free workplaces and behavioral accountability of leadership demonstrated the institutionalized HNI vision. Tangible evidence for the overall effect of HNI in the life of the community is found on the tee shirts of the youth, in the school hallways, and in the policies considered, passed, or envisioned that govern community and tribe. Most important were the private institutionalization of hope, strength, and action in those individuals who participated, embraced, and believed in their own processes.

The "just another grant" evolved into a movement based in the homes of each community and energized by volunteers and natural leaders. These local and untapped resources added to the many people trained and experienced through employment with Healthy Nations. All grantee sites contained a rich

source of change energy and through Healthy Nations, liberated hope and engaged people. The Healthy Nations Initiative set about as an experiment in prevention and ended with inspiring fourteen American Indian/Native Alaskan groups to assert their own brand of healing, reaching for the same goal.

Recommendations

Ideas for a Healthy Nations II

RECOMMENDATIONS

This brief section targets, in bullet format, factors or components that the authors would suggest for a Healthy Nations II project. Such factors are not exclusive to the Foundation or just to working with substance-abuse problems. They arise from the analysis of the narratives, the formative nature of this evaluation, and the experiences of the directors. Application of such recommendations will require a strong logical model, plan, and visionary commitment. These recommendations assume that the target of any future Healthy Nations-like grant-funded intervention remains community-change focused, including utilizing cultural strengths and local ownership. Formatted as succinct bullets, the rationale for their inclusion is embedded in and has been presented in the narratives and interviews.

- Integrate an evaluation component into the project philosophy and compliance requirements. Simple quantitative measures that demonstrate movement from a pre-program baseline, reflecting individual tribal site concerns, research questions, and internally stimulated data collection methods, analysis, and research collaboration structure with the granting agency, are essential for informing grantees and communities about the effectiveness of the ideas and activities. Qualitative analysis, particularly formative, that systematically records mobilization efforts and provide a contextual interpretation, should be outlined. Furthermore, simple outcome measures and social indicators, such as a brief community survey as

utilized in the quantitative retrospective chapters of this report could be employed. The expectation of participation in such a process should be initiated from the first contact.

- Utilize the National Advisory Committee differently and more extensively in a leadership support or mentoring role—informed, guided, and as an augmentation to the National Program Office. Instruction in leadership and administration as well as negotiating the intra-tribal or organization politics would possibly decrease the staff turnover. Assignment of one or two NAC mentors to a particular site over the life of the project would prove advantageous to all parties.
- Facilitate funding over a longer period, possibly using a graduated wash-out timeframe. Couple this with more explicit attention to sustainability efforts, including leveraging the granting agency's influence. This component would utilize the data from the continuous evaluation processes and collective expertise of the NAC and NPO. Community change and action demand generational approaches and support.
- Clarify the roles and responsibilities of tribal and/or organizational leadership in receiving and husbanding the grant. Help negotiate advantageous organization chart placement with efforts to secure governing board resolution to support the project.
- State clearly whether grant components are suggestions or requirements. Foster a documentation system that strongly encourages the grantee site to directly connect the logic of the activity to the intended grant

component. Such communication would facilitate more equitable attention and provide insight into the community mechanisms underscoring resource allocation. This would also decrease frustration and increase innovation.

- Institute a staged decrease in the reporting requirements to a semiannual written report and a quarterly survey. Many directors expressed concern over the amount of effort and time consumed by the reporting. The true value of the program emerged only after the essential changes unfolded over more extended periods of time (later in the project). Such insights would be adequately attended to through semiannual summary reports. The quarterly survey would be adequate to articulate innovation and early stage development of new directions and programming. Make efforts to train leadership in how to use the “reporting” to bolster internal support, political favor, and justification for sustaining the program.
- Continue to support Native communities in their effort to reduce substance-abuse-related problems and health issues through the privileging of and supporting of tradition and cultural-based solutions in living and re-creation.